COCHISE HEALTH SYSTEMS (CHS) CASE MANAGEMENT SCENARIO # D24D

1) INTERACTION OF THE CM (CM) WITH THE MEMBER AND OTHERS AS APPLICABLE

PAS information was reviewed after CM received daily enrollment roster and noted that member rolled on to CHS Roster. Initial telephone contact was made with Roger and Joyce within three working days of receipt of the enrollment roster. The CM scheduled the initial assessment within seven working days of receipt of the roster at a time convenient for Roger and Joyce. The CM introduced herself, welcomed them to the program, and set the stage for a sound working relationship based on mutual respect and trust. The CM explained that the role of the CM is to help Roger get the best health care possible within program guidelines, based on medical necessity. She explained that CMs work with doctors and providers to coordinate care, and are readily available to answer questions and address members' day-to-day concerns.

The CM provided Roger and Joyce with the CHS Member Handbook, business card, list of CHS contracted physicians, specialists and pharmacies. The Notice of Privacy Practices was provided and explained. The Authorization to Share Health Information was completed, with Joyce identified as the guardian. Joyce provided the CM with a copy of the guardianship letter. Member's rights and responsibilities were reviewed with Joyce in Roger's presence. Roger and Joyce were also given AHCCCS approved information on initiating Advanced Directives, and the CM encouraged Roger to receive the annual influenza and pneumonia vaccinations, if medically possible. The CM reviewed the covered services with Joyce and explained the cost effectiveness of services. The CM went into more detail explaining the SDAC model and family attendant care options as Joyce was very interested in these. Joyce currently has a full time job and the neighbors are checking in on Roger during the day while she is at work. Joyce stated she feels it is unsafe to leave Roger alone at any time and that the neighbors have decided to re-locate to a different area of the state. The CM informed Joyce about general supervision and how it is assessed and the criteria that must be met in order to authorize it. The CM also assured Roger and Joyce that BH services are available locally. Joyce was directed to choose a CHS contracted PCP for her brother from the list of physicians provided. The CM informed them she would contact the PCP of their choice to inquire whether they were accepting new patients at this time. If the new PCP was accepting new patients, the CM would send a new enrollment letter to the PCP including Roger's enrollment date, DOB, address, phone number, and any other insurance information. The CM informed Joyce that she would also be receiving a letter informing her of the change in PCPs. She would be instructed to request the medical records from Roger's previous PCP to be sent to the new PCP and to schedule an appointment with the new PCP within seven to ten days of receipt of the letter. The County Resources Directory was also provided to Joyce.

To begin Roger's assessment, the CM explained that a HCBS Member Needs Assessment Tool, a Uniform Assessment Tool, and the CHS Assessment Form would be completed during the assessment. These tools aid the CM in gathering information about the member's needs and identifying what home based services the member requires in order to remain in the home setting safely. The CM explained she makes a preliminary determination of services needed and then all information is reviewed with the Assessment Review Team for discussion. She explained the Assessment Review Team process and who is involved. The Assessment Review Team consists of two or three CMs with more than ten years experience, the CM/MUM RN Liaison, and the CM RN Supervisor. This team, along with the CM, discusses the information gathered during the assessment and other previous assessment information if any. The team discusses the member's situation, identifies the member's needs and makes a determination of services based on the CM's assessment information provided. The CM informed Roger and Joyce that CHS CMs follow this process for any new CHS members that require HCBS services and for any member identified as needing and/or requesting a change in current services whether for an increase or decrease. She told Joyce she would be receiving a phone call from her within two days of the Assessment Review Team meeting informing her of the services that would be authorized and that the Service Plan would be mailed for her signature. She informed Joyce that if she disagreed with the services authorized, she may note that on the Service Plan and the services would be reviewed by the CM Supervisor and CHS Medical Director. The NOA process was discussed with Joyce. The CM also completed the Behavioral Health Screening form at this time and informed Joyce this form indicates the need for Behavioral Health services for Roger. The Contingency (Back up) Plan was explained and developed. The CM explained gaps in service and member preference and how to report gaps in service if they should occur, including the 800# at AHCCCS set up for this purpose.

Joyce explained since Roger's recent move here after their mother's death, she has noticed an increase in negative behaviors. She explained their mother was able to care for him at home with some support, but Joyce is now having difficulty even with some prior behavior management training. She said Roger is resistive to care, refuses to bathe, change clothes, and take his medications. Roger has also had an increase in verbal and physical aggression, using profanity, throwing objects, and has recently struck out at her twice. He is fabricating and has recently tried to leave the house without supervision. Joyce noticed that Roger is isolating himself more in his bedroom and he says it's because he is bored and doesn't have anything to do but watch television. Joyce told the CM she tries to reward good behavior with cigarettes, but it just is not working.

Joyce also informed the CM that Roger continues to have seizures about twice a week. She is concerned that he may fall and hurt himself or hurt himself with his increased aggressive behaviors. To provide Joyce an opportunity to make an informed decision, the CM discussed homed based services versus alternative behavioral placements and the share of cost. Joyce said she would like to keep Roger home with her rather than looking for a behavioral setting at this time.

2) ASSESSMENT OF MEMBER'S STATUS AND NEEDS:

Physical status assessed as follows:

Transfer/Mobility: No difficulty with transfers or mobility reported or assessed. High risk for falls related to current seizure activity. Reevaluate in ninety days.

Bathing, Dressing and Grooming: Member is resistive to personal care, refuses to bathe, change clothes, and take medications.

Eating: No difficulty in eating reported or assessed. Reevaluate in ninety days.

Toileting: No difficulty with toileting reported or assessed. Reevaluate in ninety days.

Change in ADL function: No physical changes indicated. Reevaluate in ninety days.

Communication: No difficulty in communicating. Reevaluate in ninety days.

Summary of physical needs assessed as follows:

-Monitor for safety and risk of falls due to seizures. Joyce and Roger to follow up with PCP on history of seizure activity and current seizures.

-Needs general supervision when family/informal Support System not available related to potential for injury, impaired judgment, elopement risk, increased aggressive behaviors.

Psychological status assessed as follows:

-Address grieving and adjustment problems due to death of mother, symptoms of depression, and recent relocation to another state to live with Joyce.

-Address verbal and physical aggression, agitation, uncontrolled anger and fabrications.

Summary of psychological needs assessed:

-Needs psychiatric evaluation for verbal and physical aggression, agitation, uncontrolled anger, and fabrications.

-Needs counseling, to address loss of mother, symptoms of depression, self-isolation, and adjustment problems regarding recent relocation. Evaluation should include possible benefit of family, as well as individual, counseling.

-Needs general supervision when family/informal support system is not available.

Environmental status assessed as follows:

Roger lives with sister. He has own room. No other environmental needs assessed.

Socialization status assessed as follows:

Roger has nothing to occupy his time. He spends most of the day in his room. He has impaired judgment.

Summary of socialization needs assessed:

-Needs habilitation services.

-Needs supportive employment if appropriate.

-Needs access to SMI day program.

Community support/public assistance status assessed as follows:

Roger and Joyce need as much information as possible on community supports and public assistance, as they are new to the area.

Summary of community support/public assistance needs assessed:

-Provide Roger and Joyce with list and contacts of community/public assistance programs and groups.

3) CARE PLAN/SERVICES DEVELOPED TO MEET THE NEEDS OF THE MEMBER, INCLUDING DESIRED OUTCOMES THAT ARE MEMBER-SPECIFIC AND MEASURABLE

Physical:
-Provide Roger and Joyce a list of CHS contracted PCPs and Specialists.
-If current PCP is not contracted, pick from list provided within three days and report to CM.
-Send new PCP notification letter after calling to confirm availability. Joyce to make appointment within seven to ten days of receipt of letter.
-Roger and Joyce to discuss current and past seizure activity with PCP at first visit, as well as the upper respiratory infections, and possible need for adjustment of medications and/or referral to neurologist.
-Recommend Respite care two hours twice a week until Abrio (habilitation provider) is in place, to be effective immediately.
-Contact Abrio within two days to arrange for habilitation evaluation, and complete authorization.
-Offer Smoking Cessation Program after negative behaviors have stabilized.
-Provide general supervision while Joyce is at work to be effective immediately for redirection and prompts, elopement risk, and to prevent injury from un-witnessed falls due to seizure activity, impaired judgment, and aggressive behavior. Goal is for member to remain free from injury for thirty days due to impaired judgment, aggressive behaviors, and un-witnessed falls.

Behavioral Health:
-Contact PCP to determine medical necessity and coordinate behavioral health services, including psychiatric evaluation for medications, medication management, and counseling for grief, depression, anger management and fabrications. Complete referrals within two days of identifying need.
-Contact and coordinate services with behavioral health providers within two days, providing member history and issues with anger management and personal/environmental stressors. Since the goal is to remain in own home, counseling may improve both Roger's and Joyce's coping skills to manage grief and other environmental stressors. Counseling will also provide education for Joyce in the use of positive reinforces other than cigarettes for rewarding positive behaviors. The Behavioral health professional will recommend frequency of visits after intake, and submit monthly progress reports to the CHS Medical/Utilization Management division and CM.
-Complete Initial BH Consultation for review and recommendations by the BH Coordinator.
-Contact local BH provider within two days to coordinate access to the Comfort Zone, a day program for individuals with SMI diagnoses.
-Contact Abrio within two days for in-home evaluation to assist with behavioral management. Goal is for member to have a decrease in verbal and physical aggressive episodes and exhibit a decrease of self-isolation tendencies within two months.

Housing/home modifications: None indicated.

Socialization:
-Contact Abrio within two days for an in-home evaluation to assess the benefit of habilitation services, including acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside in an HCBS setting. -Services needed would also include behavioral management, supported employment (if appropriate), and escorts to day programs such as the Comfort Zone. Goal is for Roger to be less resistive to care and show improved social interactions by a decrease of verbal statements of feeling bored within one month.

Community Support/Public Assistance:
- Discuss available resources with Joyce and Roger including: ViCap (volunteer group), TBI support groups, other groups as appropriate, NAMI, Cenpatico providers (explore newly available providers and services in the area), Comfort Zone, HEE booklet, County Resource Directory, and Public (financial) assistance agencies. Goal is for Joyce to have contact with at least one community support group within one month.

Service plan completed and mailed to Roger. Contingency plan completed and mailed to Roger and agency. Authorizations entered into health information system and sent to providers. Completed CA160, CA161 and CA165.

Medical
Management

Purpose: Along with the Medical/Utilization Management (M/UM) tasks of monitoring care and service delivered to members by contracted providers, the purpose of the Utilization Management (UM) program is to execute processes that assess, plan, implement, and evaluate UM activities as specified in AMPM Chapter 1000. This is done through utilization reviews that audit the effectiveness of the UM program, review medical appropriateness of services provided, and review provider performance in providing cost-effective care. CHS strives to ensure that AHCCCS covered services are delivered in a way that is consistent with current medical knowledge and standards. The UM Plan is monitored to ensure that activities do not have an adverse impact on medically appropriate care via the review of any denials, focused studies, negative utilization trends, and/or member grievances.

Overview: Utilization data is collected and analyzed in the following broad categories: prior authorization and referral management, concurrent review, retrospective review, and internal process review. Over or under-utilization will be determined by randomly selecting specific CHS services and collecting data to compare utilization patterns among providers, members, and case managers. The information gained is reviewed with CHS staff and the providers. For any identified issues or concerns, discussion and/or written communication is accomplished in consultation with the Medical Director with suggestions for a corrective action plan (CAP) if needed. Examples of specific utilization review activities follow.

Utilization Review of Pharmacy Services: The drug utilization review process is outsourced to United Drugs, our Pharmacy Benefit Manager (PBM). M/UM staff reviews and evaluates the appropriate utilization of services delivered to members. The utilization data provided by the PBM is used in the evaluation of providers during re-credentialing and in the renewal of contracts. The drug utilization program conducted by our PBM includes, but is not limited to: a) prospective review of all drugs before dispensing and all non-formulary drug requests; b) concurrent drug therapy monitoring of selected members; c) retrospective drug use review; and d) pattern analysis. The PBM provides a formal, quarterly report of these activities in written format and meets with M/UM staff to review same as needed.

Based upon the PBM's utilization data, education of prescribers and CHS professionals will be geared toward common drug therapy problems. These will be based upon utilization patterns with the aim of improving safety, generic usage, prescribing practices, adherence to formulary, and therapeutic outcomes. An analysis of these interventions and an assessment of the effect of the interventions on the quality of care will be included in next year's review.

M/UM staff reviews member medication utilization on a monthly basis. If a member has prescriptions for ten or more medications, the member's PCP is sent quarterly the member's specific pharmacy report, is asked to do a medication review, and asked to evaluate medical need and utilization. M/UM staff also review member medication cost reports monthly for medication costs of $400 plus per month. The PCP is sent the member's specific pharmacy cost report quarterly and is asked to do a medication review with an evaluation of medical need and utilization. Quarterly, PCPs are also sent "Report Cards" that compare their utilization to other physicians contracted with CHS. This is offered to physicians in hope of encouraging increased use of generic medications and reduction of costs per member per month. Information regarding variances in utilization data are reviewed during M/UM Nurses meetings and reported to the M/UM Performance Improvement Committee (M/UM PIC). Our PBM reports that CHS prescriber's use of generic medications is the highest in the State working with that PBM, indicating that our efforts have been effective in this area.

Utilization Review of E.R. Services: Data regarding utilization of ER services is gathered monthly through the use of "Doc Util" reports from our claims management system. Over utilization of E.R. services is defined as: 1) a member with three (3) or more E.R. visits within a three month period; 2) a PCP with three (3) or more members with E.R. visits within a three month period; 3) a nursing home with three (3) or more members with E.R. visits in a three month period; and/or 4) an emergency room visit diagnosis that does not indicate a sudden onset of a medical condition.

Utilization Review of Repeat Hospital Admissions: Data regarding utilization of repeat hospitalizations is also gathered monthly through the use of "Doc Util" reports from our claims management system. Data indicating over

utilization of repeat hospital admissions is defined as: 1) a member with three (3) or more admissions within a three month period; 2) a PCP with three (3) or more members with admissions within a three month period; and/or 3) a nursing home with five (5) or more members with admissions within a three month period.

Utilization Review of Durable Medical Equipment: To evaluate the appropriate utilization of DME services delivered to members, data from our claims processing system is reviewed on a monthly basis (or as needed) for specific CPT codes. This utilization data of DME is used in the evaluation of providers during re-credentialing and in the renewal of contracts. The process of obtaining DME and medical supplies is coordinated through Case Management. Case managers are required to complete a DME log on each HCBS member upon admission and update at 90-day visits as needed. These logs are maintained in the member's record. On a daily basis, M/UM nursing staff review the authorization and utilization report. When an authorization is identified as potentially inappropriate, the case manager is notified to provide background information that may support the medical necessity for service. If the service is not assessed as medically necessary, the case manager will follow up with the requesting provider or initiate a quality of care concern process as indicated. In addition, M/UM staff receives utilization reports from our contracted DME provider on at least a monthly basis. This data is also used to identify concerns or trends.

Utilization Review of HCBS: To evaluate the appropriate utilization of services delivered to HCBS members, skilled home health data is reviewed. This Utilization data is used in the evaluation of providers during re-credentialing and in the renewal of contracts. It is also used to compare authorization patterns among case managers and among the network of HCBS providers.

Utilization Review of Specialist Visits: To evaluate the appropriate utilization of services delivered to members, specialist visits are reviewed at least bi-annually using paid claims data. This utilization data is used in the evaluation of providers during re-credentialing, and in the renewal of contracts. Data indicating over utilization of specialist referrals is defined as: 1) a member with four (4) or more specialist visits within three (3) months; and/or 2) a PCP with ten (10) or more members with specialist visits within three (3) months.

Utilization Review of Behavioral Health Services: To evaluate the appropriate utilization of services delivered to members, behavioral health utilization data is reviewed at least quarterly using paid claims data. In addition, MSAS staff requires a monthly summary report and statement of goals with all requests for continuing behavioral health services. Two to three high profile members are reviewed monthly at the Behavioral Health Utilization Workgroup meeting to more closely monitor both the under and over utilization of BH services. Some records are also sent to a contracted Behavioral Health consultant to review appropriateness of treatment and progress towards goals. This utilization data is used in the evaluation of providers during re-credentialing, and in the renewal of contracts.

Utilization of Specialty and/or Ancillary Service Referrals: The Primary Care Physician (PCP) is the focal point for managing each member's medical care, including coordination of all specialty and/or ancillary services the member may require. If a referral to more specialized services is necessary, the PCP or designee will complete a referral form including clinical information and submit to CHS for authorization. The requested health care professional is responsible for keeping the PCP informed with respect to the member's care. Primary Care Physician referrals are reviewed quarterly for over/under utilization. This information may be forwarded to the PCP's office for their information and review.

Management of the overall referral process and under/over utilization of referred services is accomplished through a joint effort involving: Medical/Utilization Management, Case Management, Finance, Providers and the PCP. Support services and non-emergent transportation are authorized by Case Management, as is DME up to $500. Referral utilization reports are generated to enable CHS to identify under and over utilization issues on an ongoing basis. Formal chart audits are conducted on any physician identified as potentially under or over utilizing services. This information is communicated to the appropriate physician and to the Medical Director. A focused review and a Plan of Correction for physician utilization are included if necessary. This information is reviewed and acted upon during the re-credentialing process.

Medical Claims Review: The M/UM staff conducts retrospective reviews of certain claims prior to payment. The reviews are conducted to ensure the medical appropriateness of the services delivered and to monitor utilization patterns. All non-Medicare inpatient acute hospital claims and all outlier claims are reviewed for medical necessity and appropriateness. Other claims may receive Medical Review as deemed necessary for services that are identified

as potentially over-utilized, medical need is questionable, or procedures reported are different from those authorized. If the documentation is insufficient to support the medical necessity of the services, the claim is pended and returned for additional information. All claims that are denied due to medical necessity are reviewed by the Medical Director. Some claims are denied by M/UM Nurses, due to procedural issues, no auth, wrong provider, wrong dates of service, duplicate claims, and/or incorrect coding. The following claims are forwarded to M/UM by Finance for medical review on a daily basis: Discrepancy between Auth # and Charges/Services Billed, Inpatient claims for Non-Medicare members over $5,000 billed, all outlier claims, high dollar/high volume – Non-Medicare only, all hospice, Dialysis – Non-Medicare, Dental, DME with Medicare EOB Denials, Ambulance transportation Medicare and Non-Medicare, and all Non-Medicare Therapy claims.

Underutilization of Services: In all of the analysis activities described above, M/UM staff will also review cases for the possibility of under-utilization of service. Data indicating under utilization of services or providers is defined as: 1) a member complaint of inadequate referrals to providers; 2) a PCP with no referrals to providers within a six-month period; and/or 3) a Quality of Care concern indicating inadequate care of referrals for care. If under utilization occurs, a plan of action will be developed. Outcome Reports are completed annually to address the results of the year's collection of data.

Results from Utilization Review Activities: The ultimate goal of all of the review and analysis activities described above is to ensure that CHS members receive appropriate medical care to optimize their overall health status. This will allow them to "age in place" as long as possible, in the least restrictive setting, and to ensure they receive medically necessary, ALTCS covered services in the most cost effective manner by the most appropriate contracted CHS' providers. When problems regarding under utilization, over utilization, or inappropriate utilization of services are identified, the M/UM department takes a lead role resolving these identified problems.

Information regarding variances in utilization will be reported to the M/UM PIC. Evaluation of the quality of services provided will be reviewed during M/UM Nurse Meetings and reported to M/UM PIC on a quarterly basis. The following items will be addressed by the M/UM Manager at the M/UM PIC meetings: 1) Problem areas identified; 2) Interventions and plans of action; 3) Analysis of interventions; and 4) Changes to interventions.

Typically there are many factors that can adversely affect utilization. The first step taken when opportunities for improvement are noted is education. M/UM staff provides education to individual contractors, facilities, CHS staff, and to members. Many times, once the provider or staff is made aware of the noted trend, immediate corrective action takes place. The M/UM department continues to closely monitor utilization after a trend is corrected to be certain that the corrective action will be long-lasting.

After education is provided and the trend continues, or if the trend could impact member safety, M/UM staff requests a written plan of correction with timelines from the provider involved. In most cases, the contracted provider or facility responds quickly and appropriately, the plan of correction is accepted by M/UM staff and the Medical Director, and the M/UM staff will continue to monitor the situation to be certain that the problem has indeed been corrected. If the identified trend involves several providers and/or members, M/UM staff may consult with the Medical Director and write specific protocols and/or practice guidelines to assist in the delivery of care. These protocols and guidelines are also reviewed by the M/UM PIC for their input prior to distribution and use.

In the event that a trend is not corrected or if the contracted provider or facility does not submit an acceptable plan of correction, admissions/referrals to that facility may be suspended. If this action does not result in the submission of an acceptable plan of correction, then CHS would give notice to the provider or facility of intent to terminate the contractual agreement with them. If the unresolved trend involves a medical provider, the case is always referred to the Medical Director for intervention and resolution. If the trend is serious in nature or is determined to be repetitive, the Peer Review Committee will be requested to review the case and take action as appropriate. The M/UM staff also may refer cases outside of CHS when appropriate to involve other agencies, i.e., AHCCCS, BOMEX, AzDHS, APS, CPS, etc.

The CHS Concern Forms will be used to record issues that involve utilization that may have affected member's health, safety or well-being; and will be discussed at the M/UM PIC meetings.

See attached Sample Utilization Reports presented to M/UM PIC.

SAMPLE UTILIZATION REPORTS 2010

REPEAT ER/ADMISSIONS VISITS

Oct. 01/09-Dec. 31/09	Jan. 01/10-Mar. 31/10	April 01/10- June 30/10	July 01/10 – Sept. 30/10
# Members with 3 or more ER Visits: 5	# Members with 3 or more ER Visits: 5	# Members with 3 or more ER Visits: 7	# Members with 3 or more ER Visits: 9
# PCPs with 3 or more members with ER Visits: 1 (P Patel)	# PCPs with 3 or more members with ER Visits: 0	# PCPs with 3 or more members with ER Visits: 0	# PCPs with 3 or more members with ER Visits: 0
# NFs with 3 or more members with ER Visits: 0	# NFs with 3 or more members with ER Visits: 0	# NFs with 3 or more members with ER Visits: 0	# NFs with 3 or more members with ER Visits: 0
#ALF's with 3 or more members with ER Visits: 0	#ALF's with 3 or more members with ER Visits: 0	#ALF's with 3 or more members with ER Visits: 0	#ALF's with 3 or more members with ER Visits: 0
# Members with 3 or more Admissions: 4	# Members with 3 or more Admissions: 2	# Members with 3 or more Admissions: 0	# Members with 3 or more Admissions: 0
# PCPs with 3 or more members with Admissions: 0	# PCPs with 3 or more members with Admissions: 0	# PCPs with 3 or more members with Admissions: 0	# PCPs with 3 or more members with Admissions: 0
# NFs with 3 or more members with Admissions: 0	# NFs with 3 or more members with Admissions: 0	# NFs with 3 or more members with Admissions: 0	# NFs with 3 or more members with Admissions: 0
#ALF's with 3 or more members with admissions: 0	#ALF's with 3 or more members with admissions: 0	#ALF's with 3 or more members with admissions: 0	#ALF's with 3 or more members with admissions: 0
Members presented with Concerns: none	Members presented with Concerns: none	Members presented with Concerns: none	Members presented with Concerns: none

HOSPITAL UTILIZATION

Oct. 01/09-Dec.31/09	Jan. 01/10-Mar. 31/10	April 01/10-June 30/10	July 01/10-Sept 30/10
Total Admissions: 183 Total BH Admits: 7 Total Rehab Admits: 2 Average LOS: 5.9 Average BH LOS: 9 Average Rehab LOS: 18 Top Diagnosis: PNEUMONIA - 17 COPD 9 UTI 8 # Medicare : 153 # Non-Medicare: 30 #Behavioral Medicare: 2 #Behavioral Non-Med: 5 #Rehab Medicare: 1 #Rehab Non-Med: 1	Total Admissions: 174 Total BH Admits: 0 Total Rehab Admits: 11 Average LOS: 7.8 Average BH LOS: 0 Average Rehab LOS: 12 Top Diagnosis: PNEUMONIA - 29 CHF - 11 UTI - 10 # Medicare : 146 # Non-Medicare: 28 #Behavioral Medicare: 0 #Behavioral Non-Med: 0 #Rehab Medicare: 7 #Rehab Non-Med: 4	Total Admissions: 172 Total BH Admits: 4 Total Rehab Admits: 4 Average LOS: 8.1 Average BH LOS: 5.5 Average Rehab LOS: 18.8 Top Diagnosis: PNEUMONIA - 27 UTI – 14 SEPSIS - 8 # Medicare : 147 # Non-Medicare: 25 #Behavioral Medicare: 2 #Behavioral Non-Med: 2 #Rehab Medicare: 2 #Rehab Non-Med: 2	Total Admissions: 141 Total BH Admits: 0 Total Rehab Admits: 2 Average LOS: 6.1 Average BH LOS: 0 Average Rehab LOS: 24.5 Top Diagnosis: CHEST PAIN - 14 CHF – 8 PNEUMONIA - 9 # Medicare : 119 # Non-Medicare: 22 #Behavioral Medicare: 0 #Behavioral Non-Med: 0 #Rehab Medicare: 1 #Rehab Non-Med: 1

% OF HCBS MEMBERS RECEIVING Housekeeping, Attendant Care, and Personal Care

APRIL 10	MAY 10	JUNE 10	JULY 10	AUGUST 10	SEPT 10
HCBS MEMBERS 546 Housekeeping 4% $4,301. Attendant Care 63% $306,286. Family Attend 4% $19,644. Personal Care 1% $3495.	HCBS MEMBERS 547 Housekeeping 3% $4,284. Attendant Care 61% $309,455. Family Attend 9% $30,249. Personal Care 1% $3,440.	HCBS MEMBERS 538 Housekeeping 4% $5,359. Attendant Care 61% $323,294. Family Attend 5% $17,366. Personal Care 1% $3,572.	HCBS MEMBERS 546 Housekeeping 4% $4973. Attendant Care 60% $326,577. Family Attend 4% $20,154. Personal Care 1% $3,912.	HCBS MEMBERS 539 Housekeeping 4% $3,724. Attendant Care 56% $291,745. Family Attend 3% $15,603. Personal Care 1% $3,307.	HCBS MEMBERS 544 Housekeeping 4% $3512. Attendant Care 53% $286,353. Family Attend 7% $18,241. Personal Care 1% $3,128.

% OF MEMBERS RECEIVING HHN and HHA SERVICES

APRIL 10	MAY 10	JUNE 10	JULY 10	AUGUST 10	SEPT 10
HCBS MEMBERS 546 HHN 22% HHA 0%	HCBS MEMBERS 547 HHN 24% HHA 0%	HCBS MEMBERS 538 HHN 21% HHA 0%	HCBS MEMBERS 546 HHN 21% HHA 0%	HCBS MEMBERS 539 HHN 22% HHA 0%	HCBS MEMBERS 544 HHN 22% HHA 0%
$28,622.	$27,877.	$31,114.	$31,136.	$31,832.	27,201.

Pharmacy Utilization Review Data – Presented at M/UM PIC meetings

First quarter (Oct – Dec 09) **CYE 2010**
*Cost per member per month was $52.84 pm/pm
*High cost meds: Central Nervous System, Pain Relievers, and Endocrinology
*87.30% generic use
*Total dollars CHS paid for medication this quarter $146,160.00

Second quarter (Jan – Mar 10) **CYE 2010**
*Cost per member per month was $41.94 pm/pm
*High cost meds: Central Nervous System, Pain Relievers, and Endocrinology
*88.04% generic use
*Total dollars CHS paid for medication this quarter $114,502.00

Third quarter (Apr – Jun 10) **CYE 2010**
*Cost per member per month was $40.58 pm/pm
*High cost meds: Central Nervous System, Pain Relievers, and Endocrinology
*88.27% generic use
*Total dollars CHS paid for medication this quarter $110,423.00

Fourth quarter (Jul– Sept 10) **CYE 2010** *Cost per member per month was $40.49 pm/pm
*High cost meds: Central Nervous System, Pain Relievers, and Endocrinology
*88.89% generic use
*Total dollars CHS paid for medication this quarter $108,237.00

Outcomes/Improvements: The success of the prior auth department continues to produce significant savings by directing physicians to less costly formulary alternatives. Projected annual savings: $31,000 based on monthly savings from formulary alternatives switches and/or medications discontinued.

CHS has observed that the costs, types of medications, percentage of formulary medications used and percentage of generic use has remained stable throughout CYE 2010. An area that continues to see significant improvement is the use of generic medication. Overall, generic use by the CHS population was approximately 87% the previous year. By increasing efforts in coordination with our PBM to encourage prescribing providers to use generic medications, our generic medication use has maintained at a high level and also slightly increased to an average of 88.04% (with a fourth quarter high of 88.89%). PBM has also instituted a Prescriber Recognition Program for those prescribers who are utilizing high number of generics and communicating exceptionally well with CHS and PBM. In CYE 2010, 98% of our contracted PCP's followed the formulary 100% of the time which also contributed to significant cost savings. We will continue to evaluate the impact of this program next year.

The ongoing goal of pharmacy utilization review is to provide our members with high quality care in a cost effective manner. The current efforts of CHS in pharmacy utilization promote this goal.

COCHISE HEALTH SYSTEMS (CHS) MEDICAL MANAGEMENT # D26

Overview: Over the course of eighteen years, CHS has developed many systems of checks and balances to identify and capture unfavorable utilization patterns and implement strategies for process improvement both internal and externally. Some examples include Health Information System (HIS) edits, Pre and Post Payment review of claims, diligent monitoring efforts by staff, as well as providing member and provider education whenever needed. CHS is dedicated and prides itself in operating a plan with Program Integrity that ensures members' needs are met while maintaining fiscal responsibility.

Provider Example: There are several examples CHS could use to demonstrate our Plan's Program Integrity, such as the HCBS attendant care project, but we have chosen to outline a unique experience that served as a useful mechanism for program improvement. This example began with the identification of an unfavorable utilization pattern with a small group of psychiatrists in our network.

Prepayment Review: through our prepayment claims review process, CHS identified an issue when a provider submitted claims without prior authorization. These claims, as per our process, were sent to the Medical Utilization and Management (M/UM) Department for prepayment claims review and were subsequently denied. The primary reviewing RN in the M/UM department is also a certified professional coder and has been doing claims review for CHS for over ten years. The Providers were notified of their Claims Dispute (CD) rights when the denial was sent. The Provider initially billed code 90882, one of the highest reimbursed codes on the ADHS-BH code matrix. (NOTE: this code was subsequently identified by AHCCCS as a non-covered code). The description of this code is Environmental Intervention for Medical Management. Following the claims review, the M/UM department ran a specific provider utilization report to determine the frequency this code was being billed. Due to the utilization pattern discovered specifically with these providers, an onsite review by CHS RN Surveyors was conducted in the Tucson facility where our members were placed. The RNs found member charting notations for this services/code to be almost identical (a possible unfavorable data pattern) for all of the members being reviewed. In each case, the rendering provider documented "...environmental intervention on the patient's behalf." These notations met the codes definition almost verbatim from the Current Procedural Terminology (CPT) manual. However, after consultation with the Skilled Nursing Home where the members were residing and upon review of the medical records in question, the notation and coding did not align with the actual services rendered to the members at the facility.

Providers' Education: As the reviews were being conducted, CHS attempted to work with the Providers and office manager, including an onsite visit by CHS key staff to educate the provider and attempt to mediate the situation. In addition, CHS attempted to educate the provider with each claims denial, offering specific documentation to demonstrate the claims coding guidelines specified in the CPT Manual. During this time, the Providers resubmitted claims utilizing a different code, 99367. The particular code became effective in January 2008 in the 2008 CPT Manual and is used to bill for a Medical Team Conference with an Interdisciplinary Team. CHS COO/Provider Services Manager sent correspondence to educate the provider by reinforcing the specific CPT guidelines; however, the Providers failed to submit documentation demonstrating compliance with the guidelines set forth in the CPT manual for the use of this code. Based on claims system edits and/or medical review, the Providers' claims were denied. Again, the denials included CD process education. Following this, after multiple denials, phone calls to/from CHS, the Providers submitted a CD.

Claims Dispute: The provider's CD involved approximately twenty members, approximately fifty-eight DOS spanning several months. Once the Providers submitted the CDs, an acknowledgement letter was sent within the five-day timeframe and explained that a decision would be rendered within thirty days. Not only did the Providers submit a CD, but also sent a letter to the CHS Director and to the AHCCCS Director. The CHS Dispute and Appeals department conducted a thorough review of this case and found that in almost all instances, the Providers failed to meet the guidelines set forth in the CPT manual. The claims also failed to adhere to the rules/regulations of the Provider Participation Agreement, such as correct coding initiatives and were in breach of the CHS contract for the submission of CPT 99367. The Dispute Department conducted a twelve-month review of each member's CHS chart using Case Management and M/UM Chart information and found that the Providers did not perform the required face-to-face meeting with the member within sixty days as outlined in the CPT manual about the use of this code. In fact,

in many cases, the members had not been seen by the provider in many months, even though medications adjustments/orders were noted. Of the twenty cases and approximately fifty-eight DOS in this CD, there were very few that were overturned and paid. The initial denial decision was upheld in almost all of the claims and the Providers were advised of their rights to request a fair hearing. Through this investigation, CHS learned that the billed services were actually Staffings (Case Conferences) held at the Skilled Nursing Home each Tuesday for two hours per session. Personnel at the facility who participated in these Staffings stated that sometimes the Staffings were even shorter – the session started at approximately 10:00 AM and rarely went two full hours. The Staffing included a presentation of residents that are more recently challenging or cases the staff needed assistance on from the Specialist Provider. Files were presented for review and action taken as necessary. The members were not present during the Staffings and sometimes the session included reviews of more than ten members (estimate). These Staffings were not exclusive to CHS residents; the meetings were held for all residents at the SNF. CHS found many aspects of this case concerning and the case was forwarded to the AHCCCS Office of Inspector General.

Hearing: Following receipt of CHS' CD Decision, the provider filed a request for fair hearing and CHS forwarded all information as required by Federal, State regulations including AHCCCS policy to the Office of Hearings and Appeals. The hearing in the matter was held in Tucson on June 9, 2009. CHS was represented by the CHS Leadership Team members, Legal Counsel, and Medical Director. The primary physician Complainant and his office manager also attended and all parties testified.

Hearing Results: the Appeal was denied and the decision was in favor of Cochise Health Systems. The AHCCCS Director's Decision stated that "the Complainant failed to meet their burden of proof showing, by a preponderance of evidence......and that the greater weight of evidence provided that the denied claims were denied for failure to hold the face to face meeting and use of proper use of CPT code 99367". The Decision was supported by the Administrative Law Judge prior to the AHCCCS Director's final ruling.

Successful Interventions: CHS has many mechanisms in place to help identify provider issues, particularly ones that evolve into unfavorable utilization patterns. The ultimate goal is to prevent any patterns developing into chronic conditions. In this example, CHS initially identified issues through the claims adjudication process where the claims were flagged based on coding edits. The claims were then reviewed by the M/UM department where claims data and member files where analyzed. These actions opened up what Cochise Health Systems refers to as "a can of worms". When the claims were disputed by the Providers, CHS discovered a significant issue / unfavorable utilization pattern. The investigations for both the CD process and in preparing for the hearing showed that the Providers billed $150.00 per member per Staffing for a total of two hours. This included all cases that were reviewed each Staffing where members were not present. In some cases, members had rarely been seen by the provider as noted by the documentation, reports produced by CHS systems, and as noted on the Notice of Claims Dispute Resolution.

Herein CHS has described an unfavorable utilization pattern that had a successful intervention. The claims were denied, processed through the Grievance System Process, and most importantly, when the case was heard by an Administrative Law Judge and subsequently evaluated by AHCCCS, the decision was favorably rendered on CHS' behalf. For CHS, the Director's Decision is most important as it validates our actions and efforts to operate and maintain a program that provides quality care to our membership while maintaining fiscal responsibility through Program Integrity for the past eighteen years. While the OIG declined to open this case for a full investigation due to the relatively small dollar amounts involved, CHS is hopeful that our reporting efforts put these Providers and this utilization pattern on the radar, so to speak, at AHCCCS since these Providers see many ALTCS clients in Pima County besides our CHS members.

COCHISE HEALTH SYSTEMS (CHS) MEDICAL MANAGEMENT # D27

Purpose: The goal of the CHS Disease Management (DM) Program is to increase self-management and prevention of chronic disease while improving the knowledge base of our members with chronic diseases such as diabetes, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), arthritis, cancer, stroke and/or depression. Smoking risk factors include Cancer, Respiratory Disease, Heart Disease, Diabetes and Stroke. The result of our efforts should be a reduction in utilization of Emergency Room services, inpatient hospital stays, and an overall improvement in member health and outcomes. Traditionally DM programs are built around a specific disease or diagnosis. The lack of integration in many traditional DM programs has led to suboptimal results. Current literature reveals many difficulties associated with the traditional DM program model. Based on the unique needs of the ALTCS population, in particular the prevalence of co-morbid conditions, CHS utilizes an Evidence Based program as the model for Disease Management. Chronic disease accounts for seven of ten deaths each year in the United States and accounts for 75% of the more than $2 trillion spent annually on health care in the US. Poverty is a significant contributing factor and Arizona is in the bottom ¼ in the nation for poverty with more women than men in this category. Eighty percent of older adults have at least one chronic condition; fifty percent have at least two.

Maintaining these members with chronic diseases in the most integrated setting by enabling prevention and self-management can potentially avoid or delay the need for institutionalization. The opportunity for self-management of chronic conditions fits well with CHS' approach to Member Centered Care. The ultimate goal is to afford our members the opportunity to live a healthy life in the least restrictive setting possible.

The Program: CHS's DM Program is an integrated approach to health care delivery. The goals are: to improve health outcomes and reduce health care costs by identifying and monitoring high risk populations; assisting members and providers in adhering to identified evidence-based treatment guidelines; promoting care coordination; increasing member self-management; optimizing member safety; and improving practice patterns of providers. The Self-Management component of the CHS DM Program is the Stanford Chronic Disease Self Management Program (CDSMP), also known as Healthy Living in the state of Arizona. CHS is well into the process of development and implementation of this program in working with the ADHS Arizona Living Well Institute. CHS has established the foundation for this program in our GSA and has trained two staff members in the Stanford Master Trainer Program. These individuals (one CHS RN and one certified exercise specialist both employed by Cochise County) have presented three six-week workshops for members in the community. A Lay Leader Training to be held in the spring 2011 is in the planning stages. CHS is working in collaboration with SEAGO (our local Area Agency on Aging) and the Cochise County Health Department to offer the CDSMP. The CHS Healthy Living staff is also receiving mentoring from the Pima Council On Aging. These strong partnerships have enabled CHS to offer the workshop to members in the Safford area of Graham County. This collaboration will also allow for provision of the program to members in Greenlee County, thereby encompassing the tri-county area of Cochise, Graham and Greenlee GSA. Tomando Control de su Salud is the Spanish version of the CDSMP. Two trainers have been identified to become leaders for the southernmost part of Cochise County, bordering our neighbor, Mexico. A large population of members who are Spanish-speaking only reside in this geographic area. In addition to these collaborations, CHS will be providing Lay Leader Training for CDSMP to two workers from the Nogales area. The CHS Healthy Living Program Coordinator has accepted an invitation to sit on the Leadership Council of the ADHS Arizona Living Well Institute.

The program consists of:

1. population identification process
2. evidence-based practice guidelines
3. collaborative practice model including physician and support-service providers
4. patient self-management education
5. process and outcome measures
6. routine reporting/feedback loop

Population Identification: CHS selects members identified to have chronic conditions who are at the highest risk and have the high utilization cost. CHS analyzes claims and encounter data to identify these factors. Members eligible for the program are identified through coordination with Case Management, review of encounter data

reporting frequency of hospitalizations, ER visits and claims data analysis identifying the top 10% by cost and utilization. New members are identified based on findings of the initial assessment and referral from the Case Manager (CM). Providers may also refer members to the program. Quarterly reports are generated from encounter data to ensure newly diagnosed members are included in the program. All CHS members are offered the opportunity to be included in the Influenza Immunization program.

Depression is also identified as a chronic condition and is also addressed in the program. The profound impact of depression on individual and family quality of life, activities of daily living and daily functioning points to the reason for including members with this diagnosis in the CDSMP. In addition, it is known that persons with depression tend to have multiple co-morbidities with substantial interactive effects relative to suffering and cost. Older adults with depression have nearly twice the functional impairment as people without depression. According to the National Governors Association, an estimated six million American seniors have depression and only 10% of them are receiving treatment. The cost of delayed mental health care or undiagnosed mental illness is estimated at more than $100 billion annually.

Evidence Based Practice Guidelines: As previously stated, Stanford's CDSMP is in partnership with the Arizona Living Well Institute of the ADHS. ADHS partners with state and local agencies in the Administration on Aging program "Empowering Older Adults to Take Control of Their Health through Evidence-Based Health Promotion". The goal is to expand the capacity to deliver CDSMP statewide with a distribution system and infrastructure that maintains fidelity to the program and collects outcome evaluation data. The funding is provided by the American Recovery and Reinvestment Act. The ultimate goal of the project is to disseminate this project nation-wide. The Stanford CDSMP is offered in 47 states, Washington DC, Puerto Rico as well as 24 countries internationally.

Evidence Based CDSMPs can lead to substantial overall cost savings. Based on a conservative savings estimate of $500 per patient, if even 10% of the 133 million chronic disease sufferers in the U.S. entered a DM program, health care savings would be $6.65 billion in the first year alone. Subjects who take the CDSMP workshop when compared to those who do not demonstrate significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability and social/role activities limitations. They also spend fewer days in the hospital as well as a trend toward fewer outpatient visits and hospitalizations. Based upon the Stanford CDSMP's history, CHS is confident we will see similar benefits to our members who are able to participate.

Collaborative Practice Model: Assisting members and providers in adhering to identified evidence-based guidelines is, and will continue to be, a collaborative effort. The following strategies encourage physician participation and adherence to the practice guidelines, encourage member participation and input, and ensure necessary communication and feedback to providers and members:

- Physicians on the Medical/Utilization Management Performance Improvement Committee (M/UM PIC) assist with the analysis of data, provide input, and will approve and/or make periodic recommendations to the DM Program, as well as receive ongoing reports of process and outcome measurements.
- CHS will encourage providers to utilize nationally recognized medical guidelines for the treatment of qualifying diagnostic conditions.
- Primary and specialty providers will be included in ongoing care management activities and will be provided with ongoing information by telephone and/or in writing.

Member Self-Management: As a major component of the CDSMP, members and/or caregivers are provided self-management strategies developed for chronic disease conditions. An additional major component in member disease self management is improved communication strategies between member and/or caregiver and physician. The course teaches self-management skills through interaction, goal setting and action planning. Participants are asked to complete a pre and post workshop survey which includes demographic information as well as self assessment of general health condition, estimation of time spent regarding discouragement about health problems, fear about future health, worry about health, and frustrations regarding health problems. Levels the participant is affected by fatigue, shortness of breath, and pain is also measured. Information including the amount of time spent in specific activities, confidence level related to fatigue, emotional distress, health and medication management, health interference with activities, and visits to the doctor are also evaluated. The goals of the program are to teach participants to be active in

patient-doctor interaction, increase activity levels and improve chronic disease self-management skills. Results of the program indicate improved communication with health care providers, decreased frequency of days when poor physical or mental health interferes with daily activity, and decreased severity of pain.

Process and Outcome Measurement and Evaluation: CHS DM Program includes methodologies to evaluate the effectiveness of the program for the participants of the CDSMP and Tobacco Cessation Programs. Review of encounter data reporting frequency of hospitalizations, ER visits and claims data analysis identifying cost and utilization will indicate utilization of services. Additionally, data reporting institutionalization will be utilized. Comparative analysis of this type of data prior to and following program participation will be evaluated. Outcome measures include, but are not limited to, a decrease in the number of ER visits and the number of hospital days related to the disease, and percent of members remaining at Uniform Assessment Tool (UAT) level I, level II or level III respectively and avoiding or delaying institutionalization.

Annual data will be analyzed to determine the efficacy of the DM program. CHS will determine providers' compliance to national guidelines through medical records and claims review. For example, CHS will continue to measure the number of diabetics who received screening for retinopathy, nephropathy, neuropathy, peripheral vascular disease, glycemic and lipid control.

Annual data for Influenza Vaccination will be collected through a hybrid methodology. AHCCCS will initially obtain denominator data and some numerator data (influenza vaccinations) for sample members and provide the sample file in a predetermined electronic format to Contractors, with detailed instructions for collecting additional data. CHS will collect additional service and exclusion data and enter it on the electronic data file, which will then be returned to AHCCCS in the predetermined format.

Routine Reporting/Feedback Loop: All DM activities are reported to the M/UM PIC on a quarterly basis for analysis and recommendation. Outcome measures are reported and analyzed on an annual basis, while process measures are reported quarterly. An annual evaluation of the program is completed and reported to the M/UM PIC for recommendations or revisions to the program. Members' physicians are an integral part of the feedback loop and are kept up to date with changes in members' health status through communication from the Case Manager. The Medical Director may contact physicians with recommendations for changes in the clinical management of a member if indicated.

Prevention Component: The Prevention component of the CHS DM Program includes a Tobacco Cessation Program, also in the process of development. Since tobacco smoking remains the number one cause of preventable disease and death in the Untied States, it is important that smoking cessation and prevention be a part of the CHS DM Program. AHCCCS spends about $316 million in medical expenses for smoking related illness per year, which is paid by taxpayers. Getting people to stop smoking or smoking prevention will result in a savings for the state and improvement in the lives of the people served by AHCCCS. It is estimated that 36% of Medicaid beneficiaries are smokers which is another important reason that smoking cessation will be incorporated into the CHS DM program.

Another aspect of our prevention program is related to Flu prevention. Influenza presents high risk for people older than 50 years, people with certain chronic medical conditions (such as Asthma, Cardiovascular disease and Diabetes) or whose immune systems are suppressed, and residents of nursing homes or other long-term care facilities. This population should receive immunization annually. According to the Centers for Disease Control and Prevention (CDC), flu vaccine administration can be 50-60% effective in preventing hospitalization or pneumonia due to influenza among elderly nursing-home residents, and are 80% effective in preventing death from the flu. Among elderly persons not living in nursing homes or similar chronic-care facilities, influenza vaccine is 30-70% effective in preventing hospitalization for pneumonia and influenza. Thus, improving rates of influenza vaccination has significant potential to reduce death and disease, as well as costs for inpatient care among this population.

COCHISE HEALTH SYSTEMS (CHS) MEDICAL MANAGEMENT # D28

Overview: Cochise Health Systems (CHS) utilizes a systematic unified approach to the clinical decision making process by applying appropriate evidence based standards. CHS utilizes the following resources to support the clinical decision making process, providing a foundation for organizational response to clinical care situations including:

- McKesson InterQual Guidelines
- Hayes Health Technology Assessment and Consulting
- Clinical Practice Guidelines (CPGs)
- Pharmacy Benefits Management (PBM) Organization
- Medical Director Interaction and Specialty Consultants
- Ongoing Program Evaluation

All of CHS' guidelines and processes are disseminated to our providers, members, and other interested parties upon request and are available on the CHS Website. The primary focus of all of these processes is meeting the unique needs of our members in a timely and consistent manner.

InterQual: CHS has selected the McKesson InterQual guidelines to ensure that all levels of the organization apply the same evidence based clinical criteria when assessing, authorizing and evaluating clinical services. The use of a single system organization wide enables CHS to seamlessly integrate clinical evidence based processes into existing systems. The McKesson InterQual guidelines have been selected as the clinical decision making criteria by the Medical Utilization Management Performance Improvement Committee (M/UM PIC). The membership of this committee includes the CHS Medical Director, physicians from the CHS service area, the Medical Utilization Management (M/UM) department supervisor, and all members of the CHS Leadership Team. This committee is responsible for identifying and overseeing the process to be used organization wide to validate clinical decision making for members served by CHS. The InterQual system was chosen because its solid research based foundation and its flexibility meet the varied needs of our organization to strengthen and improve the standards of care and services provided to CHS members. Adoption of this nationally recognized clinical standard supports a stable format for decision making communication across the continuum of care. CHS staff at all levels of the medical utilization management process have access to the InterQual system currently through paper based reference tools and will soon have access to the latest guidelines as an electronic software program on the organization's servers. CHS's subscription to InterQual includes quarterly updates to published standards.

Process: To facilitate timely response to prior authorization (PA) requests, CHS has established a variety of protocols for addressing all requests from providers for authorization of services. Requests for services are medically reviewed initially by the Medical Services Authorization Specialists (MSAS). This review includes verification of the member's enrollment with CHS and verification that the Provider is an AHCCCS registered entity with a valid AHCCCS ID Number. A secondary nurse review verifies that the requested service is an ALTCS covered benefit, verifies that the requested service meets the guidelines of medical necessity and appropriateness; determines if the PA request requires review by the Medical Director, determines if additional documentation, information, and or medical records are needed, and determines if requested service can be provided by a contracted provider in a contracted facility at the appropriate level of care. The nurse reviewer applies InterQual practice standards, or Clinical Practice Guidelines (CPGs) as established by clinical practice protocols before issuing a PA. Requests for service that are not clearly covered by these guidelines are forwarded to the medical director for additional research and determination.

Hayes Health Technology Assessment and Consulting: CHS has a process in place for the evaluation and inclusion of new medical technologies. When a request for prior authorization for a new or recently revised therapy is received, the request is evaluated by the CHS Medical Director. The Medical Director will access Hayes On-line or other reputable sources to determine effectiveness, appropriateness, coverage as determined by AHCCCS, and availability of the technology, and will consult with the Primary Care Provider (PCP) to establish an individualized care approach to meet the members' need. Once new technology has become an evidence based standard of care, a

CPG will be developed to ensure subsequent care meets the clinical practice standard and service requests for this therapy are authorized according to protocol.

CPGs: Criteria utilized to evaluate medical appropriateness are based on information sources including national evidence based standards and CHS CPGs. These protocols have been developed with input from the Medical Director, M/UM PIC, current evidence based clinical practice standards, and InterQual criteria. These protocols cover many acute adult services, acute pediatric services, behavioral health services, rehabilitation services, and durable medical equipment. InterQual intensity of service and severity of illness (IS/SI) criteria is integrated into the decision making process for both inpatient admissions and outpatient service requests. All criteria utilized for evaluation purposes are included in CHS policies and procedures and/or work manuals. Any request for a referral that does not meet the CPG guidelines is forwarded to the medical director, along with available documentation including CPGs and all other applicable guidelines for a final decision. CHS applies this consistent review criteria to process referrals in the timelines defined in the Notice of Action Regulations.

CHS has implemented several CPGs to provide this consistent framework for assessment and authorization of clinically appropriate levels of care and treatment. Guidelines that have been reviewed, approved and implemented include: Diabetes, Influenza and Pneumonia Immunization, GERD, Osteoporosis, COPD, CHF, Obesity, Sleep Disorders, Community Acquired Pneumonia, UTI, Alzheimer's, Pressure Ulcers, and the Prevention of Shingles. If the need for added CPGs is identified or the revision of existing guidelines is needed, CHS M/UM staff will research current evidence based standards, develop a draft of the guideline and present the proposed guideline to the Medical Director and the M/UM PIC for approval and implementation.

Pharmacy Benefits Manager (PBM): CHS applies clinical decision making protocols to pharmacy services by contracting with United Drugs, an experienced PBM organization. This PBM is responsible for formulary development, formulary maintenance, and medication utilization by applying nationally recognized pharmacy protocols. The PBM interacts with primary care providers and integrates information about member physiological response to therapy to ensure appropriate usage and dosing.

CHS has established a Pharmacy Committee to provide clinical review, develop pharmacy protocols and provide oversight of pharmacy utilization. The Pharmacy committee consists of the CHS Medical Director, CHS M/UM Manager, CHS Member Provider Relations Supervisor, United Drugs Clinical Services Manager, and other staff as deemed necessary. The Pharmacy Committee addresses pharmacy based clinical decision making through the development of medication protocols based on currently available information related to efficacy, utilization and medical diagnosis. This committee meets biannually or more often as needed.

To ensure communication among M/UM staff regarding clinical decision making protocols, results of oversight, or changes to protocol, M/UM nursing staff meets on a weekly basis. The agenda for these meetings includes NOA/Prior authorization status, clinical process changes if any, protocol updates or changes, and reports related to oversight or policy updates. Once monthly, all staff in the M/UM department meets to ensure communication related to processes are disseminated to all levels of the department. Additionally, all staff members participate in Quality Circle meetings in a monthly basis. The membership of the Quality Circle groups includes representation from all departments of the organization to ensure that changes in processes affecting one area are communicated within and incorporated into all levels of the organization.

Medical Director Interaction and Specialty Consultants: Throughout all of the processes described above when issues are referred to our Medical Director that she is not comfortable in evaluating, CHS contracts with several specialty consultants with whom she can confer. These specialists include a dentist, an internal medicine physician, a pediatrician, a geriatrician, a Behavioral Health consultant, the Medical Director of another ALTCS PC (for secondary review on appeals), and we are currently pursuing an agreement with an ophthalmologist. These specialty consultants are also involved in the development of CHS CPGs. Our Medical Director has been with our program since its inception 18 years ago and is very familiar with AHCCCS rules, regulations, coverage guidelines and has been intimately involved in the development of all CHS M/UM processes. She is an experienced, board certified family practice physician, and is currently also employed in an Urgent Care setting outside our GSA. Our Medical Director knows many of our contracted providers on a first name basis and has worked with or referred to them for

many years. Those relationships, as well as her experience and current involvement in the provision of direct patient care, greatly enhances her effectiveness and credibility with our contracted providers and other medical professionals. Our Medical Director also participates regularly in the AHCCCS meetings for Medical Directors and considers this group another resource for her in clinical management decisions.

Ongoing Program Evaluation: CHS conducts annual testing to ensure inter-rater reliability and to ensure consistent application of the clinical criteria by all M/UM staff. The testing group includes the Medical Services Authorization Specialists (MSASs), Medical Utilization Management (M/UM) nurses and the CHS Medical Director. The test includes a minimum of twenty-five (25) questions and/or case based scenarios related to the process of prior authorization, application of appropriate clinical criteria, timely service request response, and the concurrent review process. Appropriate responses include medical review criteria appropriate to requested services based on InterQual guidelines. An acceptable test score is eighty percent (80%) or higher. If a score of at least eighty percent (80%) is not achieved, the staff member will receive re-education and will also be reevaluated. The staff member will be retested within ninety (90) days until a passing score is achieved.

On a quarterly basis, five percent (5%) of all prior authorization documents and five percent (5%) of all concurrent review forms are reviewed by the M/UM Manager. The sample includes referrals from prior authorizations completed by all MSAS staff, and concurrent review performed by M/UM nursing staff. A 100% review of all authorizations is also done on a monthly basis by the M/UM Manager to monitor adherence to timeliness standards. Data from this secondary review is collected on each reviewer and reported back to the M/UM PIC to validate a consistent application of CHS protocols, prior authorization protocols, and InterQual criteria.

Quality
Management

Identification of Quality Improvement Opportunities: It is the responsibility of all Cochise Health Systems (CHS) staff to continuously evaluate the program for problems, to identify concerns, and to recommend changes that may improve quality of care and cost-effectiveness. Many tools are used to identify quality improvement opportunities including Trending Reviews, Quality of Care Concern Monitoring, Fraud and Abuse Prevention/Detection/Reporting (Compliance Program), Nursing Facility Retrospective Chart Review, Nursing Facility Monthly Review, Primary Care Physicians' Member Medical Record Review, Provider Reviews (excluding PCP and Nursing Facilities), Member Surveys, Provider Surveys, Quarterly Member/Provider Council Meetings, Skilled Home Health Monthly Review, Assisted Living Facilities Provider Monthly Review, and Assessment of Member Care.

Copies of all Quality of Care (QOC) concerns and improvements or action plans are kept on file and are reported to the M/UM Performance Improvement Committee (PIC) during quarterly meetings. The QOC concerns are also logged monthly on the Quality of Care Log and are tracked monthly on the Concerns Review Form. QOC concerns are secured and stored in a locked file in the M/UM office.

Trends determined through the QOC process that continue to be a concern (unable to resolve through a Plan of Correction), and are related to behavioral health, contracts, finance, case management, M/UM, or administration will be discussed with the respective supervisor to review the issue and develop recommendations for resolution.

Expressions of Dissatisfaction (EODs), which functions as an informal complaint process, are tracked monthly on the Member Expressions of Dissatisfaction and Provider Complaints – Issues Log. This Log is reviewed at least quarterly to ensure resolution of informal complaints and to identify emerging trends. If through review of EODs a trend is noted, it is documented on the Trending Report Form, and referred to the M/UM staff for further action. Informal Complaints that are not able to be resolved by case management or any other CHS division will be treated within the M/UM section as QOC concerns. If not appropriate for QOC concern process, the informal complaint will become a grievance.

Selection of Performance Improvement Projects: Another tool utilized by the CHS M/UM department is the Performance Improvement Project (PIP). PIPs may be developed to address member care deficiencies identified in the assessment processes described above. M/UM staff also continues to conduct studies as required by AHCCCS. CHS CYE2010 PIPs include: 1) Reducing the Inappropriate Refusal of Influenza Vaccine among Long Term Care Members; 2) Management of Diabetes; 3) Timeliness of Initiation of HCBS Services; and 4) Advanced Directives.

The PIP selected by CHS staff is Pressure Ulcer Prevention and Care. This study is designed to evaluate the performance of CHS Contractors serving the ALTCS Elderly and Physically Disabled (E/PD) population in minimizing the prevalence of pressure ulcers, and to support good health outcomes among these members through preventive measures. It is expected that Contractors will achieve and/or sustain rates for prevalence of pressure ulcers that are below the national average.

Processes Used to Implement or Enhance Multi-departmental Interventions: Once opportunities for quality improvement are identified, CHS strives to implement multi-departmental interventions to improve care or services. Examples of these interventions are listed below:

- On admission, CHS case managers identify language barriers with members. Interpreters are identified for member advocacy. CHS maintains a Cultural Competency Plan and educates and re-educates members, staff and providers on an annual basis. CHS maintains an extensive data base of staff and resources qualified to act as interpreters and assist in translation of up to 150 languages. CHS recruits new staff with a preference for bilingual skills.
- Members are strongly encouraged to have at least one PCP visit a year documented in the Medical File. Documentation must address the disease processes, the member's health status and interventions considered to be the standard of care for identified diseases states. During Retrospective Chart Review of PCPs, the assessment focuses on current lab values (as well as those within the time frame of the study period), documentation of pain management efforts, flu/pneumonia vaccination status, medications, pathologic

- fractures, evidence of Advanced Directives, as well as any other benchmark standards appropriate to the member's disease state.
- In retrospective chart review in SNFs, the assessment focuses on flu/pneumonia vaccination status, documentation of pain management efforts, evidence of Advanced Directives, and documentation of interdisciplinary team involvement that includes members and their families.
- Assessment and interventions provided through skilled Home Health providers are monitored by CHS staff. Home health providers submit monthly oversight reports including pressure wounds, UTIs, Falls, and emergent hospital encounters which are tracked and trended.
- CHS has implemented the Stanford Chronic Disease Self Management Program model with communication between Case Management, the M/UM nurses, as well as coordination with the Cochise County Health Department and local Area on Agency.
- CHS considers education of providers and members the single most important intervention in disease management. Vehicles that have and will be used to conduct this education include mailings to members and providers, Member/Provider Council meetings, updates on the CHS Web Page, County Fair, etc.

Interventions are evaluated for effectiveness by review of performance indicators at the end of each year in each PIP. It is expected that there will be a statistically significant, measurable improvement in the targeted indicators for these PIPs. Improved clinical management is expected to reduce acute problems that lead to hospitalization or emergency department visits. It is hoped that CHS members will remain longer in their homes or alternative community settings, avoiding institutionalization.

Sample PIP Methodology for the Pressure Ulcer Prevention Performance Improvement Project:

Background Data:

CHS has identified through data collection of quarterly Quality Indicators that the treatment of HCBS pressure ulcers has various treatments and outcomes depending upon the different Home Health Providers, PCP wound care approaches, and members who do self care. The approach to pressure ulcer care has been varied and the process for reporting pressure ulcer status to CHS by the providers has shown some inconsistencies. Specialty equipment such as Negative Pressure Wound Therapy (NPWT), specialty beds, and wound care supplies have been an area of high utilization monitoring within CHS. Through this study, CHS hopes to standardize and monitor HCBS treatments and services, have a more efficient method to monitor DME supplies and equipment related to pressure ulcer care, and most importantly, produce more positive outcomes for our members. The following factors increase the risk of developing pressure ulcers, and are prevalent among members in the CHS Arizona Long Term Care System (ALTCS) program:

- Advanced Age
- Impaired mobility, such as after spinal or brain injury, or with a neuromuscular disease, such as multiple sclerosis
- Being bedridden or wheelchair bound
- Having chronic co-morbidities such as diabetes, End Stage Renal Disease or vascular disease, that compromise adequate blood flow
- Fragile skin and/or urinary or bowel incontinence
- Mental disability from conditions such as dementia and Alzheimer's disease

Purpose: The purpose of this PIP is to improve the quality and the appropriate utilization of services to HCBS members who have pressure ulcers, determine barriers to HCBS pressure ulcer care and services, reduce time to healing, and decrease occurrence. This measure is designed to evaluate the performance of CHS Contracted Skilled Home Care Agencies in serving the HCBS population who have pressure ulcers, develop treatment protocols, and to support positive health outcomes among these members through preventive measures and education.

Period: The measurement period is from October 01, 2008 through September 30, 2011.

Population & Sample: The population consists of all reported HCBS members with pressure ulcers. The sample frame consists of all CHS members, regardless of age, who were continuously enrolled in an HCBS setting during the

measurement period. They must have had no more than one month of hospitalization and not reside in a nursing facility. The sample size will be determined through Indicator data reporting, case management reporting, and analysis of utilization reports. A statistical software package will be used to select a random representative sample by CHS from the sample frame. The sample size will be determined using a confidence level of 95-percent and a 5-percent confidence interval. A 10-percent over sample will be used to account for missing records.

Study Questions:

- What percent of sample HCBS members have pressure ulcers, any stage?
- What percent of sample HCBS members receive Skilled Home Health Services for pressure ulcer care?
- What percent of sample HCBS members that receive Skilled Home Health Services have pressure ulcers that healed in the home setting?

Data Collection: CHS initially collected pressure ulcer data on HCBS members based on reported ulcers. Additional information was/is obtained from case management and/or provider medical records to identify sample members. M/UM staff identifies members through authorization reports for DME services, Home Care services, and through authorization query reports. We also further identify members by analyzing utilization reports of supplies based on ICD-9CM diagnosis codes 707.XX. There is also interdepartmental communication with case managers who report pressure ulcers to M/UM staff. The case manager also works closely with members to encourage notification to them as early as possible when the member has any skin breakdown.

Data Validation: The sample is validated to ensure that members meet criteria for inclusion in the study and that data collected from sources meet numerator criteria. This data is validated through review of a random sample of members selected for the denominator as well as those not selected, and a random sample of numerator data collected during the initial phase of data collection. Data provided by Home Care Agencies and/or Case Management must be accompanied by documentation of wound care.

Indicators: The population will be stratified by CHS to include HCBS members who have pressure ulcers, and received skilled home care services, and those who have pressure ulcers and do not receive home care services. The numerator is the combined number of HCBS members who had one or more pressure ulcers during the measurement period, and received Skilled Home Health services plus the number of HCBS members with pressure wounds during the measurement period that received no Skilled Home Health Services. The denominator is the number of HCBS members during the measurement period, the number of HCBS members who receive Skilled Home Health Services for pressure ulcer care, and the number of HCBS members who received Skilled Home Health Services for pressure ulcer care and had ulcers that healed.

Analysis Plan: Data is being collected and analyzed utilizing quantitative and qualitative analysis techniques recommended by the National Committee for Quality Assurance (NCQA). The numerators will be divided by the denominators to produce indicator rates. Barriers to quality issues including over or under-utilization on supplies/treatment to pressure ulcer care is being identified. Barrier/Causal analysis is being done, utilizing techniques recommended by the NCQA. Based on the barriers identified, strategies and interventions will be proposed. Results also will be analyzed by demographic variables including, age, gender, and race/ethnicity, and availability of skilled Home Health Services. The results of the study will be used to improve member care and outcomes related to Pressure Ulcers. Trends will be identified and addressed as appropriate. The results of the Study will be shared the M/UM PIC and with individual providers to solicit their participation in improving member care. CHS will establish a way to share best practices and study results with all CHS PCPs to improve awareness and ultimately member care.

Peer Review is a process through which CHS evaluates the necessity, quality or utilization of care/service provided by a health care professional/provider. Peer review is conducted by other health care professionals/providers from the same discipline or with similar or essentially equal qualifications who are not in direct economic competition with the health care professional under review. The process compares the health care professional/provider's performance with that of peers or with community standards of care/service. All providers are informed of the CHS Peer review process and the grievance system process through the CHS Provider Manual, contract provisions, monitoring process (particularly the initial onsite review), and the process is also listed on the CHS website.

Purpose: The purpose of the CHS Peer Review Committee (PRC) is to improve the quality of medical care provided to members by health care practitioners/providers and to verify the qualifications of and ensure the competency of network providers. The scope of the Peer Review process includes cases in which there is evidence of quality deficiencies in service provided, or the omission of care or service, by a participating or non-participating health care professional or provider. The CHS PRC is chaired by the CHS Medical Director and other members are contracted providers from the healthcare community. The participants are peers of the same or similar specialty as those providers being reviewed, or CHS obtains external consultation should a particular specialty not be represented on the PRC. When a behavioral health (BH) specialty is being reviewed, an external contracted BH provider is consulted as part of the peer review process.

Responsibilities of the PRC: The PRC is responsible for making recommendations to the Medical Director regarding credentialing decisions, such as peer contact, education, credentials, and limits on new member enrollment, sanctions, or other corrective actions. Responsibilities may also include (when deemed necessary) recommendations to the Medical Director for written referrals to appropriate regulatory agencies such as (not all inclusive) Arizona Medical Board, ADHS, APS, CPS, AHCCCS OIG, for further investigation if the PRC determines that care was not provided according to federal/state guidelines and standards. The report would not be duplicated if already reported during the Quality of Care (QOC) concern resolution process.

CHS ensures that all information identified, utilized and reviewed in the peer review process is kept confidential and is not discussed outside of the peer review process. CHS PRC reports, meeting minutes, documents, recommendations, and participants are kept confidential except for purposes of implementing recommendations made by the PRC. All members sign a confidentiality and conflict of interest statement prior to each PRC meeting and CHS ensures that committee members do not participate in peer review activities in which a direct or indirect interest in the outcome may exist for that member.

The PRC meets at least quarterly, or more frequently as deemed necessary, and activities are carried out in executive session. These meetings are held in tandem to the CHS Credentialing Committee and the Medical Utilization Management Process Improvement Committee (M/UM PIC). The PRC also evaluates cases referred for review based upon any information identified through the quality management process. Documentation is available to AHCCCS upon request for purposes of quality management, monitoring, and oversight.

Performance Monitoring Modalities for the PRC: Expressions of Dissatisfaction (EOD) and QOC Concerns are tools put in place to respond to member grievances and provider complaints issues. However, these tools are also useful mechanisms to receive data and feedback and help manage the network. This includes the quality of medical care provided to members. These tools also help identify any cases in which there is evidence of deficiencies in quality of care, or the omission of care or service by a participating or non-participating health care professional or provider. Any provider deficiencies identified through EOD or QOC are forwarded to the PRC for action.

Provider Credentialing: The CHS credentialing process, which adheres to the guidelines set forth by AHCCCS, provides another means to identify and address any provider quality of care deficiency. Each provider is initially credentialed and is then re-credentialed every three years thereafter. Part of this process entails the Provider Profiling Process completed by the M/UM department. Each provider file that is re-credentialed is reviewed based on CHS historical data including EOD, QOC concerns, provider utilization, member complaints and survey results. This data is then reviewed by our physician panel to determine if the provider performance is satisfactory and meets our threshold of

expectations for network providers. The credentialing files are then forwarded to the Credentialing Committee for review and approval. Any files that contain any concerns that warrant consideration (per AHCCCS policy guidelines) by the PRC are set on the agenda for Peer Review Executive Session for review and action.
Provider Monitoring: One of the most important and effective means of identifying provider performance issues are the Operational Onsite Reviews. CHS conducts operational onsite monitoring to ensure the provider complies with all Federal, State and local legislation, rules and regulations relating to the provision of services under the terms of the agreement. The Provider is also evaluated to ensure that the provision of services is in compliance with AHCCCS Rules & Regulations (Acute Care), ALTCS Rules & Regulations, Arizona Department of Health Services Rules & Regulations, and the Arizona Revised Statutes. The surveyor will report any care concerns through the QOC Concern Process through the CHS M/UM section. Substantiated cases concerning healthcare providers are then forwarded to PRC for review and action.

Provider and Member Surveys: These are mailed annually to gather information regarding the network and about the organization. These also help CHS identify any provider performance issues. The surveys cover a range of topics including satisfaction with services, timeliness of service provision, and satisfaction with providers/network. CHS also conducts random annual physician accessibility surveys during regular office hours based on standards developed and approved by the Leadership Team and M/UM PIC. This survey feedback helps CHS identify any provider performance issues that may need improvement. The results are analyzed by the Leadership Team and M/UM PIC for trends that may lead to review by the PRC. Given the limitations of information submitted on surveys, CHS would pull the healthcare professional file if any concerns were noted, conduct research including provider monitoring if necessary, and gather data through internal mechanisms such as EOD and QOC should any trends be noted. The provider credentialing file and other documentation would then be presented to the PRC for review and action.

Interdepartmental Collaboration: CHS has in place an interdepartmental process that serves to promote coordination and communication across disciplines and departments within CHS. This is accomplished through regular meetings of the Leadership Team, Quality Circles, staff meetings, Inter-rater Reliability Workgroup meetings, and other workgroups as needed. The purpose of this collaborative process is to improve ongoing communications among CHS departments, with particular emphasis on ensuring coordinated approaches in medical and quality management. This internal collaboration is another feedback mechanism that allows CHS to monitor the performance of our providers and quickly remedy any situations before they develop into crisis or chronic situations. Any potential care concerns that are identified within our internal forums are reviewed by the Leadership Team to determine if a QOC concern exists. Any substantiated concerns regarding healthcare professionals would then be forwarded to the PRC for action.

PRC Executive Session: The PRC meets quarterly, or more frequently as deemed necessary, and is chaired by the CHS Medical Director. PRC meetings are held in executive session and are highly confidential. Findings/actions by the PRC are documented and maintained in the provider's credentialing file. Agendas and Minutes from the Executive session are maintained by the Provider Relations/Contracts section. Providers found in default of contractual obligations by evidence of a quality deficiency in the care or service provided (or the omission of care or service by a participating or non-participating health care professional or provider) are formally notified by the Medical Director in writing of the finding. Possible actions may include 100% review for a period of time such as a three months or six months depending on the severity of the issue, suspension of privileges for the provision of services, and possible termination. All actions are in accordance with CHS contract provisions, state and federal guidelines, and AHCCCS policy.

Analysis and Trending: The PRC activities are reported to the M/UM PIC each quarter. Confidentiality is maintained for each provider and case and/or aggregate only data is presented. In addition, the information is annually submitted in the M/UM annual plan to AHCCCS. The Cochise County Board of Supervisors is also notified of PRC activities through the M/UM Annual Report which is reviewed and signed by the County Administrator each contract year. The CHS Leadership Team and PRC analyze the outcome measures of the PRC meetings and address any clinical issues through performance improvement processes. The results are implemented by the M/UM Manager in collaboration with other Team Leaders and the Medical Director. CHS utilizes the data and implements process improvement processes/projects to improve the quality of care delivered to our members. This may include changes to policies, processes or protocols to improve the delivery of care. With eighteen years of experience as an ALTCS Program Contractor, CHS is able to demonstrate its expertise in operating a program through positive Operational and Financial Reviews conducted by AHCCCS, including an overall high level of satisfaction on satisfaction surveys from members and providers throughout our many years in operation.

COCHISE HEALTH SYSTEMS (CHS) QUALITY MANAGEMENT # D31A

Overview: Cochise Health Systems (CHS) received notification of an immediate jeopardy (IJ) situation at a contracted assisted living facility (ALF), Golden Ages. This facility has been operating without a license for several months. CHS and the Arizona Department of Health Services (ADHS) have been working with the owner to submit the license renewal and supporting documentation to no avail. Six Medicaid members reside in this facility, four are CHS enrolled and two are enrolled with another Medicaid Contractor. Placement options are limited in this rural county. The need to immediately transfer these six members from the ALF was identified. The goal was to transition these members to available safe placement alternatives including:

- Transfer to the one available SNF – Quail Ridge
- Transfer to home
- Transfer to ALF in another GSA area/town
- Transfer to non-contracted ALF in GSA

Immediate Actions: Prior to the close of business on the day of notification CHS Case Management Team will have assessed member's needs. If there were any indications of unmet medical needs, the member would be transported to PCP's office or local Emergency Room for assessment and treatment if indicated. After consultation with the Contracts Department, services available in the area and outside of the service area were identified including:

- LTC facility respite stay
- Critical Access Hospital (CAH) respite stay
- Out of Geographical Service Area ALF
- Non-contracted ALF in the county
- Transition members home to HCBS with supportive services

Due to the emergent nature of the circumstances, CHS utilized an interdisciplinary response to ensure that members will be transferred in a safe and appropriate manner that affords members and family choice and the least restrictive environment possible. Due to the urgency of this situation, the case manager conducted a face-to-face welfare visit at the facility and notified the members verbally of the need to transfer out of the facility. This encounter was documented in the members' case files, in addition to contact with the family/POA/Public Fiduciary and the PCP's notification of the anticipated move.

The Case Management Supervisor, Cindy, called the other ALTCS program contractor to determine their placement needs and explore collaborative efforts to ensure the safe transition of their members, and availability of placement contracted within that system. Cindy offered any assistance that CHS staff could provide the other PC since we would have more intimate knowledge of the local facilities and placement options available.

The Chief Operating Officer (COO) Paula, informed the CM Team that she had contacted three out-of network ALFs and only two ALFs, Lightning Ridge & Maple Grove, could take an additional placement at this time. The third ALF, Benson Ranch, was in the process of opening more beds and was awaiting final ADHS approval on the expansion. This facility anticipated eight openings in less than thirty days time.

Case Management Responsibilities: The Case Management clerk obtained a list of the current CHS contracted providers for the case manager to share with the members and/or family/representative. In this particular situation, the CM notified the member/POA/Public Fiduciary of the limited options for placement. The case manager supported the member/family decisions on available placements.

The lead case manager contacted families of the four members residing in the facility to explore the possibility of temporarily taking members back into their homes. One family thought they would be able to take their mother home and so the lead CM contacted a contracted Home Health agency to request a "stat" referral to get nursing assessments/interventions in place immediately. CM also contacted caregiver agencies to determine their availability for housekeeping, personal care and respite care. The one member that was considering transition into home based

services was made aware of the Community Transition benefit. The Case Manager provided a written brochure to member and family describing the additional HCBS services available through CHS and the additional support services available in Cochise County.
Three of the families contacted did not have the resources to take care of the members at home even with supportive services in place, so the CM discussed the limited placement options available. Since members and family requested that their placements remain in the local area, the lead CM planned placement of these three CHS members in a respite stay in the only available LTC facility. Placements of these residents in a respite stay allowed CM and the COO the time to develop alternate contracted placements with members in a safe environment. When this third ALF, Benson Ranch, was discussed with the CHS members/family, the ALTCS residents wanted to stay together if possible as they had developed close friendships and would miss not seeing their friends. The decision was made to wait for the Benson Ranch ALF openings. With member and family consent, the CM Care Team made the decision to accept Quail Ridge Rehab and LTC facility placement in a respite stay for these members. The CM was informed by facility staff that one of the members assigned to another PC was requesting placement with these three CHS members as she had become close friends with one of the CHS members. The CM immediately contacted the CM from the other PC to again offer assistance if needed to make this happen.

CM began coordination and collection of information for the receiving facility(s). CM then faxed this information to Benson Ranch ALF for review to determine if they could meet the members' needs. This documentation included the following: H&P, CXR, TB skin test, Face sheet, Active problem lists, Physician's progress notes and orders, Lab results and pertinent x-rays, Specialty consults of therapy evaluations, and Behavioral progress notes. The Golden Acres caregiver was alerted to collect all medications sheets and medications on the CHS members and have them ready to transfer with the specific member at time of discharge.

The CM Supervisor, Cindy, along with the CM Team, reviewed the members' needs through the use of the Uniform Assessment Tool (UAT) completed during the most recent ninety day assessments and CM case notes. The review team evaluated and assessed the needs of the four members. This information was then shared with the accepting nursing home, to establish the plan of care and ensure member needs are met. The CM Team arranged for all documents from Golden Ages ALF to be faxed to Quail Ridge Rehab and the LTC facility so that Quail Ridge staff could begin care planning. The Social Worker, Susie, contacted the CHS CM Team with additional questions and issues, regarding an accepting PCP, family involvement to facilitate the move, DME to include w/c, walkers, and discharge date and time.

When a facility is identified accepting these members the CM Team will:

- Initiate any services
- Arrange for transportations
- Assist in data collection and dissemination

Paula, the COO, notified AHCCCS regarding the termination of contract of Golden Ages ALF and the notification of the immediate move of the four CHS members. She stated that Case Managers had offered the members and family the following options: 1) LTC facility respite stay, 2) CAH swing bed, 3) OON/GSA ALF, or 4) to transition members home to HCBS status with supportive services, such as visiting nurse, housekeeping, personal attendant care, meals on wheels, and the personal emergency response system. Paula stated she was awaiting input from Case management on the decision of member and family. All members would be transferred to the new facility or to home within twenty-four (24) hours of the time CHS was notified of the IJ.

Paula, in preparation of a possible out of network (OON) placement, requested that the OON facilities to provide a copy of their current ADHS licensure, and faxed the ALFs in question the CHS contractual requirements. She also alerted the M/UM Department of the names of OON ALFs and had the M/UM nurses review their most recent survey results on the ADHS website. Contracts Specialist, Marty, pulled the contractual file on Quail Ridge Rehabilitation Center and Long Term Care Facility and verified that all contractual requirements were met at this date and reviewed the respite rate stay. By placing members in a respite stay at the LTC or in the CAH, this would allow additional time for contracting with another ALF or obtaining a letter of agreement. Within 8-10 hours, transportation of members would occur.

Contracts Responsibilities: The Contracts Department contacted the one LTC facility and identified the available beds. Paula spoke with Chuck, the administrator of Quail Ridge Rehabilitation Center and Long Term Care Facility, and he verbalized that they could take the CHS members as well as the other two ALTCS members on a respite stay if requested. Paula also contacted the Copper King Hospital and spoke with Robert, the Director of Nursing, to identify if any swing beds placements were available for these members. The DON, Robert, said he would discuss this with the CEO, Mrs. Richardson, and call her back. Paula was contacted by Mrs. Richardson stating that they only had one bed available, and would keep this available for a CHS member. Paula, the COO, also contacted several out of network ALFs to determine if a letter of agreement could be arranged.

M/UM Responsibilities: The M/UM Department had specific tasks and assumed responsibility for the following:

- Notified the Medical Director of the IJ and member move
- Verified authorizations in place for any DME
- Processed all new authorizations
- Processed all Specialist referrals
- Transferred authorizations in place (transportations already authorized)

One important action taken by the M/UM Department was the initiation of the Quality of Care (QOC) process, to determine why this facility could not renew its licensure, and to review if there was any neglect or abuse of the members. M/UM notified AHCCCS of the QOC after results of the final investigation were complied and the outcome of member placement and any problems identified with this IJ transition process. The M/UM Manager, Rebecca, contacted the CHS Medical Director to request that she make contact with the Medical Director of Quail Ridge Rehab and LTC Facility to discuss care of the members. She requested the Medical Director of Quail Ridge to assume care of these members while they were in a respite stay at this facility. Emergent care needs were identified and the Medical Director of Quail Ridge was made aware of continuation of care requirements.

Follow Up: Each department of CHS had a different area of responsibility for following up to ensure that the transition to the new facility commenced as planned. The CMs were responsible for the following:

- Documenting the required Client Assessment and Tracking System (CATS) data entry and completing a Cost Effectiveness Study.
- Providing the member, family, or responsible party with the names of the agencies, caregivers and if there was a new Primary Care Physician needed.
- Assisting with scheduling the initial appointment with the new PCP if needed.
- Conducted an on-site visit within ten working days following the members' change of placement to evaluate services and assess if further needs have been identified.
- Make appropriate changes in CATS and CHS HIS system. Verify with the member that services are being received. Transfer case to new Case Manager, if applicable.

M/UM nursing staff would contact the facility and schedule a monitoring visit with the next 120 days and include the Contracts Department staff. They would also advise the facility of the quality indicators that are monitored related to member care. When there is a neglect situation identified, M/UM would notify Adult Protective Services (APS), but in this situation no notification was required because Golden Ages ALF was not negligent with care.

After Action Review: At the completion of the transfers, the CHS Team met two days later in a care conference with the CHS Director, Mary, to critique the performance after the urgent crisis was resolved to identify opportunities for improvement, and to reevaluate the CHS emergency preparedness plan. CM had conducted ninety day assessments on the four CHS members as scheduled, and M/UM had conducted their routine annual review and found the facility to be in compliance at the time of their review. Negligent care issues had not been identified by CHS M/UM department during routine site reviews and were not a concern with this facility, because the owner, Shelby, had been openly communicating with CHS Case Management and M/UM. Recommendations were made to review compliance policies and procedures for our contracted facilities and look at possible areas for improvement in managing our contracted facilities.

COCHISE HEALTH SYSTEMS (CHS) QUALITY MANAGEMENT # D31B

Overview: CHS received notification of an immediate jeopardy (IJ) situation at 4:15 pm, on a Friday, before a holiday weekend, that a nursing facility in the Phoenix area, Sun Lakes Village, will not have air conditioning/cooling available for approximately four days. Arizona Department of Health Services licensing staff, local city staff, and the Ombudsman are on site. Reporters are on the way. It is July and currently 116 degrees outside. There are 48 Medicaid members in the facility spread out across several AHCCCS Contractors. The goal was to immediately move the CHS assigned members and also assist with the safe placement of the other members.

Immediate Actions:
- The CHS Contract Operations Officer (COO) received notification of an IJ situation at a contracted nursing facility in Phoenix.
- The COO notified all department supervisors, the CHS Director, and the Medical Director.
- The Case Management (CM) Supervisor identified the CHS members residing there – a total of two.
- The COO determined that this facility was unable to provide a generator back up system for their coolant or air conditioning.
- Member needs would be evaluated by Case Managers immediately.
- Plan for coordinating transfer of members to other facilities.

CM Interventions: The major obstacle in managing this IJ situation was the distance of the facility from the CHS Office in Bisbee. The approximate driving distance was 185 miles to the facility, and the normal transit time would have been 3 to 4 hours. On a Friday before a holiday weekend, the travel time could possibly take even longer. The CHS Director, Mary, after consultation with the CHS Leadership Team, decided that the best course of action would be to send a case manager to the Phoenix facility and to have the Leadership Team coordinate the actual move from the local office. The CHS CM Supervisor, Cindy, managed the situation at the home office by coordinating arrangements and maintaining close cell phone contact with the CM, Linda, who was en route. Cindy also had the assistance of the Leadership team consisting of the Director, the M/UM Manager, the CFO, the Financial Manager and the COO.

As the CHS CM, Linda, departed the Bisbee office, the CM Supervisor, Cindy, immediately contacted the other two program contractors' CM supervisors, Manuel and Stephanie, in order to begin collaboration and determine if they would be able to conduct an immediate wellness check on the two CHS members involved. They had already been alerted and were onsite at the facility. The other CM supervisors confirmed to CHS CM Supervisor Cindy that the outdoor temperature was 116 degrees Fahrenheit and reported that the indoor temperature was 106 at this time. They also reported that the facility had cooling fans and portable swamp coolers in place, but the temperatures were rising and some members were developing signs of mild dehydration. The facility DON notified the local EMS of the IJ situation and requested assistance in evaluation, treatment and possible movement of the residents. The residents who were showing signs of mild dehydration were evaluated by EMS services with the potential of sending these members to the nearest emergency room. The EMS staff also assisted to "triage" members to be transferred in priority order depending upon medical needs. The CM supervisors from the three AHCCCS plans identified the need to transfer the 48 members to other facilities during the interval while Sun Lakes Village completed their cooling/air conditioning repairs.

Preparation for Evacuation: The three AHCCCS contractors' CM Supervisors explored placement needs of the 48 members and identified a list of facilities that had available beds. They forwarded this information, along with possible facilities that may have open beds, to the CHS offices. The Leadership team and the CM Team combined efforts to quickly find facilities that had open beds. Time was of the essence due to the extreme temperatures, so the team effort was the most expedient approach. They started with the closest proximity facilities and then expanded their search to the outlying Phoenix suburbs. Ombudsman staff was onsite as well as Adult Protective Services (APS) staff. APS was notified by the facility when they self-reported the incident. Arizona Department of Health Services (ADHS) staff was onsite and assisted to coordinate efforts to move all 48 residents to alternate locations. The CHS CM clerks collected data on authorized services for the three CHS members. The Lead CHS CM contacted family/POA/Public Fiduciary and the PCPs to apprise them of the situation. Families were asked if they could

temporarily take the members home for a few days, with the help of home care services. The lead case manager with the care team assessed the members' needs based on the Uniform Assessment Tool (UAT). It was found that both CHS members had a recent evaluation and required behavioral health placement and even a temporary transfer to HCBS setting was not the appropriate level of care for these two members. The Lead CHS CM, in the Bisbee office, had also notified the CHS Medical Director and faxed copies of the history and physicals on file, as well as case notes. During collaboration with the three AHCCCS plans, the CHS team identified four facilities in the Phoenix area that would be able to accept these 48 members for a short stay in their facility. The CHS Lead CM began the process of collection of the following information for the receiving facilities, and faxing this information to the one facility willing to take both CHS members. The CM faxed the following information:

- H&P
- CXR
- TB skin test
- Medications administration records (MARs)
- Face sheet
- All problem lists
- Physician's progress notes and orders
- Lab results and pertinent x-rays
- Specialty consults of therapy evaluations
- Behavioral progress notes

The accepting facilities had staffing conferences to determine if they could meet the members' needs. The Scottsdale Village Square facility social worker contacted CHS to inform us that they would be able to take both of the CHS members with BH needs. In collaboration with the other AHCCCS plans, it was discovered that this facility had their own transportation van and was willing and able to transport residents to the new temporary residence. The CHS Lead CM contacted the PCP to determine if they had privileges at this new temporary facility and found no problems with this. Transportation was also coordinated through local ambulance transport companies and the receiving facilities transport vehicles were also utilized.

Contracts Responsibilities: The CHS COO contacted the other AHCCCS plans and determined the facility rate schedule that they were granted. Paula, the CHS COO, called the facilities to arrange for a Letter of Agreement in order to facilitate the acceptance of the two CHS members. Paula, the COO, notified AHCCCS regarding the immediate jeopardy situation and the need for the immediate temporary move of the two CHS members to an alternate LTC facility. She also prepared a statement for the news media for our local area since we had been notified that this would be on the late night news broadcast.

M/UM Responsibilities: The M/UM Department had specific tasks and assumed responsibility for the following:

- Notified the CHS Medical Director of the temporary member move
- Verified authorizations in place for any DME or other services
- Processed all new authorizations for the temporary facilities
- Processed all ER transfers
- Transferred authorizations in place (transportations already authorized)

Outcome: The two CHS members were relocated to Scottsdale Village Square. The CM, Linda, who traveled to Phoenix, went directly to this facility since the members had already been transported there by the time she arrived. A wellness check was done and the CM also visited with the staff and DON of the facility. The CM, Linda, verified that the families had been notified of the transfer and updated them on the members' conditions.

Within four hours, the entire Sun Lakes Village facility had been evacuated and all residents moved to other locations. The members were placed as follows:

- The two CHS members were transferred to Scottsdale Village Square.
- Six members went to the Chandler Regional Medical Center ER for moderate dehydration and were then transferred to Maryland Gardens Care Center. Fifteen other members were also transferred to Maryland Gardens Care Center.
- Five members were returned to their homes with in-home care services arranged to assist the family members.

- Eight members were transferred to Tempe Center Village Care Center, and
- Twelve members were transferred to Chandler House Care Center.

Follow Up: Each department of CHS played an active and important role in managing the IJ situation and had specific areas of responsibility during the crisis, to include follow up activities. The CMs were responsible for the following:

- Document the required Client Assessment and Tracking System (CATS) data entry and Cost Effectiveness Studies.
- Provide the member, family, or responsible party with the names of the temporary facility, home care agencies, and new PCP if needed.
- Conduct an onsite visit within one week to the temporary facility to assess if further needs have been identified and to assess member acclimation to the new placement. A visit will also be scheduled at the former residence, Sun Lakes Village, when the cooling system was functional.
- Complete an ALTCS Member Change Report. Make appropriate changes in CATS and Wells system.
- Verify with the member that services are being received.
- Transfer case to new Case Manager, if applicable.

M/UM nursing staff initiated a Quality of Care concern, requested documentation and a corrective action plan (CAP) from Sun Lakes Village. In the CAP, CHS asked the facility to provide a copy of their:

- Disaster plan with backup generator availability
- Dehydration plan
- Maintenance records on the coolant system
- Internal temperature log
- Notification notice to ADHS and APS
- Incident reports on members who were transferred to the Emergency Room

At the finalization of the QOC, M/UM notified AHCCCS of the final investigation, the outcome of member placement, and any problems identified with this IJ transition process.

After Action Review (AAR): An immediate jeopardy situation of any kind can produce negative outcomes if the key players involved in providing resolution are not prepared. Due to the level of cooperation and teamwork between department members and our sister AHCCCS contractors in the Phoenix area, this incident was effectively and efficiently resolved without major incident. The CHS staff was well-prepared to handle an IJ situation that required immediate action after having recent experience with a natural disaster when a major freeze in the area occurred in February 2011 in the southern region.

The initial AAR was conducted by CHS Leadership Team later in the evening of the incident, after all members had been safely transferred. They quickly summarized the course of events and the courses of action taken. A meeting time for follow up was scheduled for 0800 on the next business day after the holiday weekend. During the formal AAR in the follow up meeting, they discussed the items listed below:

- Evaluation of transfer process.
- Review all collected documentation from the QOC concern.
- Timelines from notification to final transfer of members.
- Review CM notes following temporary placement to determine any member complaints or member issues with transfer. Were all medications transferred or were there any medications or property not transitioned?
- Evaluation of the facility reviews by Contracts, M/UM, and CM case files to determine if this was identified as a problem earlier, or if this was an unforeseen event.
- Schedule a follow up visit prior to transferring residents back to the affected facility.
- Determine if any of the costs relating to the emergent transfer of members should/could be borne by Sun Lakes Village.

Recommendations were made to have the M/UM nurses include a review of Disaster and Emergency Plans in all facilities when they conduct their annual site reviews. A second recommendation was to intensify efforts to relocate members outside of our GSA back into our GSA as soon as possible.

The single biggest difference between CHS and most other ALTCS Program Contractors is that we are mission driven rather than profit driven. The overall focus of our mission is to improve the quality of care and accessibility to that care for the members we serve. CHS staff has been committed to this mission for the entire eighteen (18) years that we have served members in our GSA, and we have the full support of the Cochise County Board of Supervisors (BOS) and Administration, and County departments in this mission. The fact that CHS members are constituents of the County BOS, as well as taxpayers in our GSA, creates an additional level of commitment by CHS staff that is not present in programs managed by other than County entities. As one entity of a much larger organization dedicated to serving all the needs of the public in our GSA, CHS can leverage our effectiveness by accessing other County programs/employees benefiting our members beyond ALTCS covered services. The mission driven mindset of every CHS employee allows us to fulfill the County's motto: "Public Programs – Personal Service". Our mission is in perfect harmony with the ALTCS guiding principles of member-centered case management (CM), consistency of service provision, accessibility of the provider network, and collaboration with stakeholders to support members in the most integrated, least restrictive setting possible for as long as it is their desire to do so. One specific measure of performance improvement to demonstrate CHS' experience in improving the quality of care and performance for our members is what began as our Attendant Care Project in early 2009. Since that time, this style of identification of opportunities for improvement expanded first into other HCBS issues and has been enthusiastically applied in many other areas throughout CHS. An explanation of this project follows.

After reviewing our monthly financials in late February 2009, it was obvious that our expenses for attendant care (AC) services had grown exponentially and that this growth could not be justified or sustained. From the 1st quarter of CY08 to the 1st Quarter of CY 09, HCBS expenses increased by just under $750,000 or 38%. Our December financials actually showed a net loss of $542,607.13 for that quarter, with the largest increase noted in AC expenditures. The number of members had remained stable and the percentage of members in HCBS vs. Institution had not really changed, so the increases could not be explained by some drastic change in member population or demographics. An in-depth analysis ensued involving all divisions in CHS, as well as staff in the County Attorney's Office and at AHCCCS.

CHS Finance and Administration first began to identify the scope of the problem by analyzing and comparing average AC hours authorized per member per month (PMPM) among all of our agencies. In comparing AC expenses from October 2007 to those in February 2009, we found increases in the average hours of AC authorized PMPM for all but one of our contracted agencies, ranging from a low of an 11.66% increase for one provider to a high of 81.82% for another provider. The average increase was 36.16%. We also found that there were huge discrepancies in average AC hours provided among the agencies. Recognizing that we needed assistance in this analysis from all divisions of CHS, we formed an Inter-rater Reliability (IRR) Workgroup to focus on this, and ultimately many other issues. The first IRR meeting was 3/3/09 and members include at least two staff from each Division: M/UM, CM, Finance, Provider Relations/Contracts (PR/C) and the Director. The first priority was to review authorizations and claims for AC hours.

Outside the IRR, we formed eight teams of CMs paired with each of the RNs working throughout CHS to review AC hours with a focus on member needs. There were 500 HCBS charts to review, each team reviewing approximately sixty cases. We started by using the timed task tool then under development, but immediately identified many flaws in this tool. We also found that the involvement of the RNs who were not familiar with the members was actually an impediment to the process, so we abandoned the teams and left the task to the CMs. As the teams and later the CMs independently reviewed the member charts, careful attention was paid to the AMPM description of AC coverage guidelines for family and spousal attendant care. In general, it was determined that AC hrs, especially for family and spousal caregivers living with members, had been grossly over-authorized for quite some time. The CMs began the labor-intensive process of working with members, families, caregivers, authorizations, and agencies to be sure that only covered services were being provided.

Simultaneously with the CM reviews, CHS Admin staff met with all of our HCBS providers individually. We shared the information we had compiled showing the overall dramatic increase in AC hours and discussed the variations among agencies. We also shared copies of actual claims with individual providers that we had identified during the CM and Finance review showing instances of AC workers billing for hours when it was impossible for them to have been in the home. The most obvious examples of this were billing for AC hours while members were hospitalized. Most of the providers with whom we met were horrified at what we showed them and vowed to re-double their efforts

in staff education and supervision. During these meetings, with input from our County Attorney's office, we also stressed the consequences of fraudulent billing and requirement of reporting these cases to OIG.

There was an unexpected, immediate, and welcome development resulting from these discussions. During these meetings, we told providers that we would re-educating CMs about changing referral patterns to direct new admits to our most cost effective contracted providers, as long as there was no preference expressed by the member. At that time, the rates per unit of AC ranged from a low of $4.06 to a high of $6.75 and these rates were not being consistently considered by the CMs when making HCBS referrals. A couple of our providers volunteered to decrease their rates immediately to be more competitive and amendments to their agreements were issued almost on the spot by our PR/C division staff! We estimate that change alone resulted in a savings of nearly $250,000 over one year.

In early May 2009, we met with CMs again to review this project. At this meeting, we listed all CMs by the average number of authorized AC hrs PMPM. We also compared authorized hours in March - May 2009 after this project began to authorized hours in October 2007. This report illuminated the huge variation among CMs – by May of 2009 the most conservative average of AC hrs PMPM was 31.10 and the least conservative was 90.18 hrs PMPM (one CM at the very top of the chart was excluded as an outlier with one member requiring 155 hrs of AC per month). The average was 67.45 PMPM compared to 57.46 in October 2007 – still a 17% increase for the same population, so there was/is still room for improvement (monthly average in January 2011 was 57.02). Also of note was that the average decrease by all CMs was 19%, but the CM with the highest average of authorized hours had only decreased by 3.54%.

Another important fact is that despite decreases in AC hours for almost all of our 500 in-home members, we only issued twenty-one NOAs because all of the other members and/or families agreed that the reductions were reasonable. Along this same line, we had only nine member appeals as a result of these NOAs. One last item of note is that 48% of the NOAs and 78% of the appeals were from members assigned to a single CM. This is the same CM who was averaging the highest number of AC hours authorized and showed the smallest decrease in AC hours as a result of this review. That CM was managing 8% of the total in-home placed members from a remote office, so clearly there was an issue with this CM. Her caseload assignment was temporarily (six months) changed so that she managed only institutionalized members. This CM was transferred to CHS main office, underwent intensive re-training with very close oversight until the CM Manager felt comfortable to reinstate her regular assignment. The over-authorization of AC hours has been resolved with this CM and all CMs auth statistics continue to be monitored and reviewed with all CMs monthly.

While the CMs focused on getting the authorizations for AC hours corrected, the Claims and Finance staff focused on reviewing HCBS claims. As an example, nine batches were reviewed that included approximately 8,000 claims from two of our HCBS providers for dates of service prior to the initiation of this project. Of these 8,000 claims reviewed, Finance staff identified an average of $10,000 per batch of dollars that needed to be recouped! It is important to note that recoupment efforts were only made for claims that were absolutely inaccurate, specifically, claims on which CHS was billed for AC hours while the member was hospitalized or otherwise not in the home. Finance staff continues to conduct this labor-intensive review by comparing the backup documentation sent with the HCBS claims against the claims we have paid to hospitals and/or transport providers for days/hours the member was absolutely not at home. CHS' requirement of these providers to submit backup documentation with claims makes us uniquely able to prevent, or at least greatly reduce, these billing practices. This would be impossible to accomplish if a PC does not have this requirement.

M/UM also became involved in this review and one RN was able to identify just over $13,000 to be recouped in a random review of 16% of the HCBS claims submitted in February 2009 by just two agencies! This more intensive review included making calls to doctor's offices for members who did not utilize CHS transport providers so there was no trip ticket as backup to review for times in/out of home. We are continuously striving to streamline this form of review and will continue to report our findings to the OIG when appropriate.

Two of our contracted providers were ultimately referred to OIG and one formal investigation was opened. While the OIG is not able to fully investigate each report we make because of the size of our claims, we still make the reports so that OIG can identify trends other program contractors may identify and report with these same HCBS providers. We are cautious in our review process and communications with providers once a referral has been made to OIG and do not pursue recoupment efforts from that provider until we receive notice from OIG that their investigation is completed. The length of time it takes from the date of report until we receive confirmation that a case will be opened and then completed is hindering our recoupment efforts. We may need to request permission from AHCCCS to recoup on claims older than twelve months at some point depending upon how this process with OIG unfolds.

Lastly, we created and AHCCCS approved a policy that allows CHS to sanction providers who are not making satisfactory efforts to address performance issues. The dollar amounts of the sanctions escalate as the number of issues identified increase, up to the ultimate sanction of termination of their contract. The availability of this tool has been a very effective deterrent to our HCBS providers in submitting fraudulent billing and also serves as a strong motivator for them to be proactive in the management of their employees and review of documentation prior to submitting claims.

CHS learned many lessons as we collaboratively worked on this project with CHS staff, providers, AHCCCS DHCM and OIG, and the Cochise County Attorney's office. Some of these lessons are:

- In terms of AC expenses.... expenses in March 2009 were $988,329, in April were $492,365, and in May 2009 were $405,496. This represented a staggering 59% reduction in AC expenses in just those first three months with no untoward member outcomes, i.e., increased ER utilization or hospital stays, or increases in the percentage of members placed outside the home. These figures contain only a small portion of dollars recouped to date.
- More important than the reduction in AC expenses is that HCBS providers are more available to provide needed services in a timely manner for our members as evidenced by our monthly NPS and Timeliness of Initiation of HCBS reports. We continue to assist our HCBS providers to identify employees who are not providing services as authorized and/or not documenting accurately. This is another way that we can ensure that our most vulnerable members are truly receiving the care they need.
- It is critically important to review backup documentation sent with HCBS claims. This was an issue identified across the board for all of our contracted providers.
- The opportunity for abusing this benefit, especially for family and spousal caregivers, seems limitless. The loudest and most frequent feedback we received about the reductions in AC hours revolved around the caregivers' discontent with their "paychecks being cut". Very rarely did we hear concern that member care was being compromised and in those cases, additional review was conducted and AC hours adjusted as needed. While the family and spousal attendant care benefit has greatly reduced the shortages of caregivers, it has also made the authorization and claims review of these services even more important. The member's signature on the backup documentation is one tool that we have to verify that services are provided as documented. For members whose caregiver is a family member or a spouse, it is nearly impossible for that member to refute the documentation when that family member or spouse is all that is standing between the member and almost certain institutionalization.
- The focus of reviewing of AC authorized hours should be on non-personal care tasks, i.e., housekeeping, laundry, shopping, etc., especially for family and spousal attendants living with the member. The timed task tool needs many tweaks, but has been a great help in making this assessment more objective and consistent.
- We need continuous focus on IRR for CMs in terms of AC authorization with education and reinforcement of standards at all times. The variations among CMs were too great to be acceptable – either the most conservative are being too conservative or the least conservative were over-authorizing services. That variation has normalized now, but bears monitoring at least monthly. The newly formed CM Assessment Team was developed as a result of this project. That team meets weekly, reviews all initial CM assessments, and re-assessments on established members if a change in AC hours is requested. This process has further improved IRR within CM.
- Constant dialogue with HCBS providers is crucial to reducing the performance issues identified. The claims we are now receiving are much improved with more accurate backup documentation. Several contractors have taken disciplinary action, including termination, of some employees based upon our reports to them, and some employees have even been reported by the providers to local law enforcement agencies.
- Constant dialogue with members is also crucial to their understanding of their role in preventing opportunities for abuse. We sent one letter to members at the beginning of this project to remind them of their responsibilities, and continue to stress this in member newsletters and on our Website.
- Lastly, we need to find a way to better coordinate our efforts with OIG after reporting suspected instances of fraudulent billing so that the recoupment process is not hindered in any way.

At AHCCCS' request, CHS presented this project as a "webinar" for other ALTCS program contractors and again at a CONG meeting at AHCCCS. CHS is very proud of the results of this project in improving the quality of HCBS care our members receive and in improving the performance of our contracted providers. It is evident that this project was successful due to the commitment of CHS staff throughout our organization. This methodology has been expanded to the review of other categories of service and work processes throughout our network and internally at CHS. This is the same level of commitment CHS has demonstrated over the eighteen years we have been a program contractor. This project is just one example of our continuing efforts to ensure our members receive the highest quality of health care services from providers who share our level of commitment to this member-centered goal.

COCHISE HEALTH SYSTEMS (CHS) QUALITY MANAGEMENT # D33

Overview: There are a variety of mechanisms in place within Cochise Health Systems (CHS) designed to capture feedback from our members, providers, internal and external customers. Through monitoring and various input processes, such as member and provider surveys, member assessments, Member and Provider Expressions of Dissatisfaction, Grievance and Appeals process, Quality of Care Concerns (QCC), Physician Accessibility Surveys, and CHS Quality Circles, we are able to effectively evaluate all aspects of our operations on an ongoing basis.

Provider and Network Feedback: The following methodologies are used to obtain feedback about the providers and serve also as a means to obtain feedback from the providers about the network design and adequacy.

- **Provider monitoring** helps identify a provider's ability or inability to provide timely services, or ability to meet the members' needs based on acuity and special needs. Existing providers are queried about any new providers in the area that may be an asset to our network.
- **Utilization reports** provide data by CPT codes, ICD9 CM codes, facility/provider or member, i.e., quarterly reviews of HCBS service utilization.
- **Provider-specific surveys** gather information such as language capabilities of staff or telephonic surveys assess appointment processes and availability of providers. In addition, providers are surveyed to determine if members arrive timely to their appointments and if they are picked up on time. This data helps CHS identify if transport providers are meeting the needs of our members.
- **Initial & Re-Assessments**-CMs use this tool to evaluate a member's needs and develop a care plan. If a member needs a particular service or provider who is not part of the network, this is communicated to the Provider Relations Department for resolution. Resolution would include a letter of agreement or a long term full status contract. These assessments also help CHS identify the member's satisfaction level with the CHS network.
- **Case Managers** are an invaluable tool used to monitor the efficacy of the network and program operations. From the onset of a case, CMs communicate with the Provider Relations department in their efforts to coordinate services. This communication occurs on a daily basis. Sometimes CMs or members know a provider is leaving before official notice is given. CMs can also express concerns if a member's needs are not being met through the existing network. CMs also assess timeliness of behavioral health appointments and may identify providers who are unable to schedule timely appointments.
- **Prior Authorization (PA) Section** identifies needs for providers, particularly specialists, with whom CHS may contract for services or use as non-contracted providers if there is not sufficient need within the population for the specialty. The PA staff also identifies possible trends for delays in scheduling appointments due to provider availability issues.
- **Member Grievances (Expressions of Dissatisfaction) and Provider Complaints-Issues and QCCs** are two other tools used to identify problems with CHS operations and the possible need to expand or change services in a particular area. These tools also provide information about opportunities for improvement in the way CHS conducts business.
- **Quality Circles**-One of the most effective means of coordination between internal departments are the Quality Circles CHS initiated in 2008. CHS has at least five separate quality circles comprised of employees from each section/department of CHS – Administration, Finance/Claims, Case Management, Provider Relations, and Medical/Utilization Management. Initially, the focus was member care, but now has evolved to workflow issues between departments. CHS has found ways to improve different processes, discovered recurring billing problems for providers, issues with encounters, and how all are inter-related. There is one main Quality Circle Log maintained by the Director created from the minutes of each Circle meeting. The CHS management/leadership team uses this log to identify any possible trends or issues needing interventions.
- **CHS also has an Inter-rater Reliability (IRR) Work Group** whose purpose is much the same as the Quality Circles in that we strive to improve and streamline our business operations. The IRR workgroup focuses on specific problems or trends identified by the Quality Circles and implements strategies for improvement. For example, the team may review the high cost utilization report or analyze monthly financial statements to determine what areas may need review and improvement. This year the focus continued to be the review of attendant care services, and extending that analysis of nursing care and DME in the home. Last year's analysis/study of attendant care services improved our focus on prepayment claims review to ensure that services are appropriately delivered and reimbursed. CHS has incorporated the provider sanction policy into contracts and has found this to be an effective tool to engage providers, especially HCBS providers, in the review of backup

documentation submitted with claims. From the IRR work group, CHS convened smaller focus groups whose purpose was to improve the process for DME authorizations, the reporting of census data monthly from CM to Finance, and another team for HCBS authorizations. The DME focus group was temporary and disbursed once new strategies and workflows/protocols were implemented. The HCBS team has been more long-standing since their scope of activities is more broad. The intent of this group, chaired by case management, is to provide oversight of the authorization of services to ensure consistency among case managers. This group also ensures that members' needs are met, particularly (but not exclusively), when providers request an increase in service hours. This group serves as a "review board" for case management where a case manager presents data collected in the initial assessment or re-assessment visit. The "review board" assists the CM in establishment of the service plan for each member. Overall, the mission of the IRR workgroup is to review covered services, identify any potential areas for improvement, and ensure that members' needs are being met while maintaining fiscal responsibility.

- **Inter-Departmental Cooperation:** This policy/process was implemented by the Director to promote coordination, collaboration and communication across disciplines and sections within the CHS. The purpose of the policy is to improve ongoing communications among the sections of the department with particular emphasis on ensuring coordinated approaches to medical management and quality management.

Other Mechanisms: Inter-departmental Cooperation within CHS is further enhanced by quarterly staff meetings, bi-monthly Leadership Team meetings, quarterly Member-Provider Council meetings, and M/UM Performance Improvement Committee (M/UM PIC) meetings.

Physician Accessibility Surveys: In conjunction with onsite facility reviews, CHS also conducts annual surveys of PCPs and certain specialist providers to determine physician accessibility, compliance with ALTCS appointment standards and contractual requirements, and to ensure that timely, appropriate medical services/advice are available to CHS members. This survey also includes out of network providers used on a case by case basis. If a prior authorization is completed for an out of network physician, that information is relayed to the Contracts Compliance Officer for inclusion on the annual physician accessibility survey. This tool is also useful in identifying potential Contractors for network development, and for credentialing purposes. The survey is conducted in a random fashion and consists of particular criteria determined by the M/UM PIC. Criteria include: how many times the telephone rings before the call is answered, how long the caller is on hold, whether or not advice was given regarding an emergency situation, and whether or not instructions were offered in more than one language. Survey results are recorded and maintained in the provider's permanent file. Those providers failing to meet particular requirements are notified and re-surveyed in three months to determine effectiveness of corrective action plans. In addition, information is submitted to M/UM for trending purposes. Results of provider monitoring and physician surveys are reported to the M/UM PIC annually as a means of verifying stability within the network. Any deficiencies or gaps in the network are reported to the Contracts Compliance Officer for immediate action.

Provider QCCs: When any CHS staff member receives a complaint and resolves the situation, they complete the Member Grievance and Provider Complaint Process and forward it to M/UM department. The M/UM staff determine the efficacy of the resolution and evaluate the log. If the resolution is agreeable to the member, the issue is closed and documentation is filed in M/UM department. If the proposed resolution is not accepted by the member within 10 days of the complaint, the member is advised of their right to submit a grievance orally or in writing, and the issue is forwarded to the Claims Dispute and Member Appeals Manager. If the issue is deemed a QCC, the issue is processed according to the QOC concern policy. Any QOC concerns or trends identified as contractual non-compliance are forwarded to the Contracts Section for action in accordance with contract provisions. In addition, the M/UM PIC reviews all QOC concerns or trends on a quarterly basis. Recommendations may be made by the M/UM PIC regarding possible action by CHS are forwarded to the appropriate CHS division manager or CEO. Providers who do not correct the QOC concern may be sanctioned or suspended from providing services until there is satisfactory resolution. If any contractor is suspected of submitting fraudulent billing or committing any fraudulent act, the provider is immediately reported to AHCCCS Office of Inspector General.

Satisfaction Surveys: Annual Provider, Member, and Behavioral Health Surveys are another source of input regarding CHS operations. These surveys help CHS identify opportunities for improvement in all aspects of the organization and implement process improvement when needed. The results identify member and/or provider satisfaction level with particular providers, lack of providers, deficient appointment standards, lengthy wait times, as well as satisfaction level with CHS internal operations. The Member survey asks specifically about each division in CHS. The surveys also may identify providers whose best practices are recognized by members. The surveys not

only enable CHS to identify limitations or gaps, but also help CHS recognize areas where providers might require education or training specific to our member population. The survey results are used to assist CHS in identifying areas of service for new development, amending work statements, or development of new training topics. The survey results are also used in evaluation of CHS employee performance when individual employees are cited by members or providers. Historically, the CHS Satisfaction Surveys have shown a high level of satisfaction with operations and responsiveness – an average of 95% satisfaction rating. The results of the surveys are available on the CHS Website.

Example #1 - Member Feedback: One example of positive changes resulting from member feedback is related to the provision of DME, in particular, the provision of specialty wheelchairs, specialty wheelchair repairs and specialty equipment in general. Our primary DME supplier for specialty items such as these was located in Phoenix with no technicians or delivery personnel based in our GSA. This resulted often times in the delay of repairs and/or deliveries due to scheduling, staffing and the distance of our members from their home office. A secondary DME company we contracted with had stopped providing these types of specialty services, which left us with one contracted specialty DME provider. When member complaints began to surface earlier this year, we studied standard delivery times and repair times from this primary provider and were not satisfied with the findings. Our solution was to obtain a contract with a second DME company, closer to our GSA, in order to share the workload. The Contracts department located a second specialty DME provider in the Tucson area that provided the services we required. Once the contract was signed and a portion of the workload was redistributed to the secondary provider, our delivery times and repair times decreased significantly. Also our member satisfaction increased and the level of services we can provide is now greatly enhanced by contracting with multiple DME suppliers.

Example #2 - Member Feedback: In early 2010, we began receiving member Expressions of Dissatisfaction that trended into two QOC concerns about our transportation authorizations. According to our policy, members were to call in to request non-emergent routine transportation and leave a message on a dedicated line with their request. The complaints consisted of missed appointments due to a lack of arranged transportation, no confirmation of their request, and the uncertainty of the process in general. Our solution was to hire a full time clerical person that would staff the transportation line during working hours. All requests were received by this one CHS staff member and authorized in a timely manner. The complaints of missed appointments and lack of transportation declined to a bare minimum. The satisfaction of both our external customers (our member population and our transportation providers), as well as our case managers and internal staff, increased by more than 50% across the board. These improvements have led to a more streamlined process that is more efficient and user friendly for our customers. In the next few months, CHS plans to pilot a program where prior authorization for transportation is not required, such as for dialysis members. We will closely monitor utilization during the pilot, but if successful this would improve member and provider satisfaction as well as reduce the workload of CHS staff in this area.

Example #3 - Provider Feedback: Education for some of our providers and their staff on our referral processes became an issue in early 2010 when we began receiving feedback from provider surveys on the difficulties they were experiencing in obtaining prior authorization for their referral requests. We determined that the primary cause of the problem in processing referrals through our system was not due to lack of provider education, but of the providers' referral staff familiarity with our processes. Referral and auxiliary office staff in many of our provider offices turn over frequently, so in order to provide education and training to the majority of our network providers, we extended an invitation to attend referral training at our location. For those clinic staff unable to attend, an informational pamphlet was sent with instructions and our referral department's contact information. CHS staff even made onsite visits to some of our providers for one-on-one training. Both our external (provider) and internal (referral staff) complaints decreased in the following months. After seeing the immediate benefits of our training, we decided to provide referral training annually in May and September for all of our contracted providers in the future.

Example #4 - Provider Feedback: One of our PCP groups requested a meeting with CHS staff to discuss prior auth requirements in general, and specifically the elements required on our Certificate of Medical Necessity (CMN) for supplemental nutrition products. Of utmost concern was the requirement for a member weight. The PCPs explained that it is extremely difficult to obtain an accurate weight on some of our more debilitated members who are the ones in most need of the supplement. The PCPs suggested that we consider the use of mid-arm circumference measures as an alternative to weight in these members. The suggestion was quickly researched by our Medical Director, determined to be a medically acceptable means of gauging weight loss/gain and CHS' CMN was immediately revised and distributed to all providers. The specific PCP group making the suggestion, as well as most of our other PCPs, were very pleased with this change.

COCHISE HEALTH SYSTEMS (CHS) QUALITY MANAGEMENT #D 34

Overview: Since its inception, CHS has worked to promote AHCCCS' vision of supporting the least restrictive environment for members with long-term care needs. The percentage of members in a home setting has risen from approximately 22% in 1993 for Cochise County to over 60% today. CHS has achieved this goal by ensuring a strong, flexible network that meets the culturally diverse needs of our members. In order to ensure the success of this endeavor, CHS monitors services and sites for members who reside in their own homes. Without feedback mechanisms to monitor our organization's operations and that of our network, CHS would not be able to maintain the goal of keeping members in the least restrictive environment. Mechanisms to monitor the Providers of HCBS include contracting, credentialing, formal onsite reviews, and other processes as outlined below.

Contracting/Credentialing: Once formal contracts are negotiated to meet and exceed AHCCCS minimum network requirements, CHS then credential each Sub-contractor/Provider. CHS ensures that Provider credentials are validated through a credentialing process and re-credentialed every three years in accordance with Federal, State and AHCCCS policy. Credentialing files contain Provider information such as (examples only not an inclusive listing) licensure, insurance and malpractice history, accreditations, work experience and history, AHCCCS Profile Information, NPI enumeration and Suspension/Debarment information through HHS-OIG. Credentialing data is collected and reviewed in a thorough, timely, and consistent manner, meets the requirements of state and federal law, and provides a means to monitor Providers to identify and address any Provider issues or deficiencies. Part of this process includes the Provider Profiling Process completed by the M/UM department. Each Provider file that is re-credentialed is reviewed based on CHS historical data including Expressions of Dissatisfaction, Quality of Care Concerns, Provider utilization, member complaints and survey results that are then reviewed by our credentialing committees. Using this data, a determination is made if the Provider performance is satisfactory and meets our threshold and expectations of network Providers.

The Monitoring Process: The responsibility for monitoring services and assessing the quality of those services lies within each division of CHS. However, that is primarily the responsibility of the Provider Relations (PR)/Contracts and Medical and Utilization Management (M/UM) Departments. Member-centered care is a coordinated effort by all divisions to identify areas of concern, take action to address those areas of concern, continually evaluate and expand the network to ensure access to care to meet member needs and choices in the home, and define and implement strategies for improvement for the organization. CHS continues to pride itself in the high quality, cost-effective, and appropriate services it has provided over the last 18 years to all members in Cochise, Graham, and Greenlee counties. The PR/Contracts Department, and M/UM Department, conduct on-site facility reviews for new contractors within the first 120 days of initiation of a contract. It is the philosophy of CHS to build strong relationships and communication lines with our Providers by personally expressing an interest in their operations, rather than being just a voice on the phone. The initial visit and training with new Providers is used to ensure that Providers understand the program and the various rules and regulations that apply to them. The training varies based on the contracted service with special focus on claims, authorization requirements, Provider responsibilities for communicating with other Providers in the delivery of care, fraud and abuse, cultural competency, elder care, gaps in services (Ball vs. Betlach), and behavioral health services. CHS also uses this time to ask the Provider for any input regarding our services, such as coordination of care with other Providers, availability of Providers to meet members' service needs (themselves or others), and suggestions for new Providers to add to the network. On-site facility assessments are typically conducted for all contracted Providers on an annual basis, or at least every three years, to ensure compliance with AHCCCS and CHS contractual requirements, and to evaluate the quality of services delivered to members. Monitoring is conducted in accordance with Chapter 900 Policy 920 and Chapter 1200 Policy 1240 of the AMPM. These Provider Reviews are used to monitor the adequacy, accessibility and availability of the Provider network. The on-site reviews are conducted using monitoring tools based upon contractual requirements, state and federal regulations and AHCCCS policy, and are specific to the Provider service type being reviewed. Monitoring assessments include (but are not limited to) a site review, review of Providers' policies and procedures including policies on drug screening, fraud/abuse, federal false claims act, emergency protocols and personnel records, verification of current licensure and most recent State survey results. As a shared responsibility, the PR/Contracts department focuses on the operational review, including an evaluation of employee records. The M/UM section focuses on the member care aspect of services as staff review the medical records component for these Providers with emphasis on quality of care and to ensure adherence to all AHCCCS guidelines. The M/UM department review process includes member chart evaluation. RN reviewers note diagnoses, treatment and follow-up care, and determine whether certain Covered Services provided (or to be provided) are in accordance with CHS and AHCCCS requirements. Surveyors also analyze any Expressions of Dissatisfaction (EOD), Quality of Care (QOC) Concerns, other pertinent records, and/or trended information gathered within the organization to evaluate the Provider's performance under the terms and conditions of the contract. Provider issues

identified prior to the on-site review are addressed during the visit to ensure the Provider understands and is able to comply with contractual requirements. CHS internal departmental forums such as Quality Circles, Leadership and Staff Meetings also help to monitor Providers and identify issues. CHS may also develop training sessions with Providers by targeting common issues identified during the monitoring process. Provider education forums include Provider Newsletters, Provider specific mailings, and quarterly Provider Manual mailings, including Provider Manual policy updates or contract amendments.

Cultural competency: During monitoring, Contractors are surveyed to ensure they have the ability to accommodate members with different ethnic backgrounds, such as bilingual staff or intake forms in different languages. Cultural competency is important for all members, including our home based members. For home based members, it would be important in terms of appropriate pairing of caregivers for in-home services. For attendants who accompany members to PCP visits, it would help ensure that members understand any medical advice or instructions given. CHS views Provider monitoring as a tool to promote cultural awareness. On-site reviews are used to identify communication barriers with members and possible means of resolution. This may include the use of other, more appropriate Providers with diverse linguistic skills and cultural understanding, or the use of translation services available to CHS members and Providers. This monitoring process helps CHS ensure appropriate delivery of services for members who reside in their own homes.

Corrective Action Plans (CAP): If the surveyor's findings are unsatisfactory and it is determined that the Provider is in default of any contractual performance obligation, CHS requests a Corrective Action Plan (CAP) from the Provider. The CAP must include goals and objectives, steps to be taken and methodologies to be used to accomplish CAP goals and objectives, and identify staff responsible to carry out the CAP within established timelines. The CAP must include plans and activities to correct deficiencies and/or increase the quality of care and services provided to members. The Contracts Department will promptly inform in writing AHCCCS DHCM, if a subcontractor is in significant non-compliance that would affect their ability to perform the duties/responsibilities of the subcontract (per AHCCCS policy). Follow up monitoring is completed by CHS to evaluate Provider improvement as outlined in the CAP. Depending on the severity of the deficiency and/or the subsequent results of the CAP, CHS may suspend modify, or recommend termination of the Provider's contract immediately. This would occur upon written notice to Contractor in the event of a non-performance of stated objectives or other material breach of contractual obligations, or upon the occurrence of any event that would jeopardize the ability of the Provider to perform any of its contractual obligations. Such determination would not be made until the dispute process has been exhausted as specified in the Disputes Clause of the Provider's Subcontract. If an adverse action were taken with a Provider due to a QOC concern, CHS would report the adverse action to the AHCCCS Clinical Quality Management Unit, and/or refer to regulatory agencies. Documentation of assessment of the effectiveness of actions taken is maintained by the M/UM department. The CAP and subsequent results are shared with the CHS Leadership Team, the M/UM Process Improvement Committee, and other stakeholders as deemed necessary including members and Providers if the Provider network is impacted.

Sanctions: Over the years our rural counties have grown and more medical services are available. It is essential to build strong ties within our community and solidify the foundation of our organization through a strong Network. Whenever possible, CHS works with Providers to manage performance issues through our CAP process as has been mentioned throughout this document. CHS uses education, training and monitoring to make sure the Provider is compliant with the CAP, reliable and provides quality services. However, CHS does recognize there are occasions when these methods are not successful. CHS developed a Provider Sanction Policy to sanction Providers for repeated sub-standard performance or other repeated breach of contract or procedural provisions. If the Provider is in default in any manner in the performance of any obligation under their agreement, CHS may, at its option and in addition to other available remedies, adjust the amount or withhold payment to the Provider until there is satisfactory resolution of the default. This sanction process is a contractual clause and the policy is listed in the Provider manual along with Provider appeal rights and process. This sanction policy was approved by AHCCCS and is in accordance with Federal and State laws. The sanction process is a mechanism used to address serious Provider performance issues. Prior to sanctioning a Provider, CHS seeks a CAP from the Provider, monitors compliance and should the Provider adhere to the CAP with no further occurrences, the CAP is accepted and the Provider agreement is not suspended or terminated. CHS does maintain the right to terminate a contract as set forth in each agreement and states that the CEO may suspend, modify, or recommend termination of the Contract. As stated above, such determination is not made until the dispute process has been exhausted as specified in the Disputes Clause of the Provider's Subcontract.

Gaps in Service: The process for identifying and reporting gaps in critical services for ALTCS HCBS members is another mechanism CHS employs to monitor services for members that reside in their own homes. Members and their CMs develop contingency plans when a member has critical services authorized and in place. This plan includes information on actions and resolutions that should occur when a gap is identified / reported. The Direct Care HCBS Providers send Non-Provision of Service (NPS) report forms to CHS CM section each month. Additional information

explaining the circumstances surrounding the NPS and the measures taken to resolve the NPS are documented on the NPS report form. The CM Supervisor reviews the NPS log, consolidates the log for multiple Providers, reviews it for accuracy, and determines which NPS events are actual Gaps in Service. The NPS and Gap logs are forwarded to AHCCCS on a monthly basis. Gap logs from previous months are also evaluated by the CM Supervisor for tracking and trending such as the comparison of Provider and member listings each month. This process helps CHS monitor the efficacy of the service delivery to members who reside in their own homes. If any member trends are identified, CM contacts the member for evaluation and corrective action. The CM also contacts the member to determine a cause for repeated gaps. CHS has determined that some of the repeat instances are due to member choice or are the result of the Provider's inability to re-staff for that particular member. In cases where the Provider is unable to staff, services are arranged through another contracted Provider. Toll-free 800 numbers are provided for the member through CHS and AHCCCS and are available 24 hours a day to each member to report unresolved gaps. Any gap that cannot be filled within the required timeframe is reported to the CHS CM immediately so that alternate arrangements can be made with another Provider. In each gap analysis that has been completed by CHS, there continues to be an extremely low incidence of gaps compared to authorized services (less than 1% overall), indicating that HCBS Providers are meeting contractual and member preference requirements in almost all instances.

Informal Complaints/Quality of Care (QOC) Concerns and Non-compliance: CHS also monitors HCBS services through informal complaints and QOC concerns. Any employee of CHS who receives input from any source regarding dissatisfaction with any aspect of a member's care, Provider performance, or CHS operation is charged to report such dissatisfaction via the informal complaint process. If there is concern involving a more serious care issue, a QOC concern is submitted. The M/UM Department collects all informal complaints and QOC concerns to track and trend for identification and corrective action. If M/UM identifies a trend with any Provider, the problem is addressed with the Provider and a CAP may be required from the Provider. M/UM notifies CHS Contracts and CM departments of any identified trends. These issues are also discussed in the CHS Leadership Team meetings held bi-monthly to determine appropriate action to be taken and by whom. The outcomes of all QOC and informal complaint investigations are reviewed at the M/UM PIC meetings. Contracts and M/UM staff examine the complaint, the efficacy of the resolution and log for trending. If determined to be a trend in non-compliance according to the contract, the Provider will be notified in writing of the deficiency and a CAP will be required. Providers who do not correct the problem may be sanctioned or suspended from providing services until there is satisfactory resolution. Ultimately, the contract may be terminated and suspected fraudulent activities are reported to the OIG.

Member and Provider Surveys: Surveys are mailed to members and providers annually and CHS uses the results to monitor efficacy of and satisfaction with services for members who reside in their own homes. The surveys cover a range of topics including, but not limited to, satisfaction with services, timeliness of services, and satisfaction with Providers/network. The survey feedback helps CHS identify our strengths as well as Provider performance issues that may need improvement. The results are analyzed by the Leadership Team and M/UM PIC for trends that may lead to Provider or internal staff education, and overall serve as a tool to improve our operations and network.

Fraud/Abuse and Non-Compliance: The Corporate Compliance Program is also a means of monitoring services for members who reside in their own homes. The Corporate Compliance Officers have independent authority and report directly to AHCCCS, OIG and/or the DHCM providing a written report within ten (10) business days of discovery. In addition to initial training, annual trainings are mandatory for all CHS staff to ensure the identification and appropriate reporting of any suspected fraud or abuse. One example of this process is the requirement that all HCBS delivered to CHS members must be documented and signed by the member/family. This backup documentation is required to be submitted prior to any claims adjudication. Several cases of suspected fraud were identified with home care agencies and the signing of timesheets for attendant care services when the member was not home. The agencies involved were required to implement a CAP and to provide a closer level of supervision of their employees. Some employees were terminated. Two agencies were also sanctioned due to repeated incidences of fraudulent timesheets. These suspicious acts were reported to the OIG and to CHS fraud and abuse coordinators who took immediate action to resolve the issues. All CHS personnel are aware of the duty to report any instance of suspected fraud or abuse to the coordinators and the combined efforts of all CHS departments provides a united front to identify and report any and all future instances of fraud and abuse.

Member Verification of Services: CHS also conducts quarterly verification of services through random/periodic audits to validate that members receive services for which CHS is billed. This process also serves as a mechanism to monitor services for members who reside in their own homes. In this manner, CHS may identify any performance issues with Providers such as billing issues or organizational issues. In addition, at least annually an M/UM RN makes a home visit to all CHS members receiving SDAC services to ensure that this particularly vulnerable population is receiving the services they need despite the absence of outside supervision by an HCBS agency.

Oral Presentation

COCHISE HEALTH SYSTEMS (CHS) QUALITY MANAGEMENT # D35

Cochise Health Systems is prepared to participate in a scheduled oral presentation when notified by AHCCCS. The names and resumes of the five participants, along with the roles each will play during the implementation phase and at least the first year of the contract, will be submitted via the EFT/FTP server no later than 3:00 PM MST on April 8, 2011.

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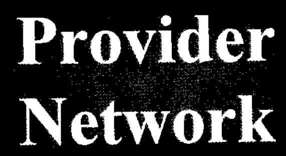
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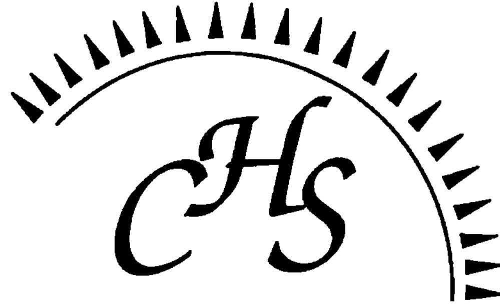

Cochise Health Systems
A program contractor for Arizona Long Term Care System and
A division of Cochise Aging & Social Services

NETWORK DEVELOPMENT AND MANAGEMENT PLAN

NOVEMBER 15, 2010

COCHISE HEALTH SYSTEMS
NETWORK DEVELOPMENT AND MANAGEMENT PLAN
NOVEMBER 15, 2010

PART I: Overview of Network Development

Purpose

Cochise Health Systems shares the AHCCCS mission and vision to reach across Arizona to provide comprehensive quality healthcare to those in need while shaping tomorrow's managed healthcare and promotes the values of choice, dignity, independence, individuality, privacy and self-determination. This is accomplished, in part, through the implementation of a Network Development and Management Plan that defines the process of effectively developing and maintaining the network to provide medically necessary covered services in a timely, cost-effective manner, while maintaining the highest quality of care to CHS members.

The Plan incorporates Cochise Health Systems' policies and procedures that structure the daily operations of the program and guide CHS toward the long-term objective of operating a program that provides high quality care and supports member choice through a diverse and flexible network that serves as a foundation for our program.

The policies and procedures include, but are not limited to, service specifications that direct CHS staff in reviewing the current network status and identifying network deficiencies gaps and/or limitations, provider guidelines, and continual monitoring of providers for compliance with AHCCCS Network Standards. This ensures appropriate availability of providers based on the volume of members, member needs, geographic location and projected growth. In addition, CHS serves as the provider liaison between the member and provider. Communication is considered a vital component of high quality care and therefore all means of correspondence are utilized. Communication is achieved through contractual amendments, the Provider Manual and quarterly updates, Newsletters, monitoring visits, provider and/or member specific communications, the provider/member council, surveys, in-services, electronic mail and our website.

To meet covered service requirements and minimum network standards as defined by AHCCCS, contracts staff reviews the requirements, conducts an initial needs assessment for each county in the geographic service area and employs a contracting process that ensures that services are reasonably accessible in terms of location and hours of operations. Initial and emergency medically necessary services are obtained by coordination of formal contracts and letter agreements with the appropriate providers and occasional use of non-contracted providers. Long-term provision of services is achieved by means of the contracting process that meets the AHCCCS program requirements and Cochise County Procurement Code. The Network is continually monitored for compliance with standard requirements. Any deficiencies or gaps/limitations are temporarily resolved with letter agreements while the formal contracting process is conducted. Identified Network deficiencies considered material changes are relayed to AHCCCS in advance of the anticipated change and any unexpected major network changes are reported to AHCCCS within one day of the change.

Long-term contracts are awarded based on type of service to meet minimum requirements for covered services and network standards. Wherever possible multiple providers are awarded contracts for each service in order to ensure continuity of care, prevent any network gaps and to provide members with a choice of providers.

A. Approval of Standard Contracts

In accordance with AHCCCS contract requirements, the Contracts Section maintains a fully executed original of all subcontracts which are accessible to AHCCCS within two business days of request by AHCCCS. All subcontracts comply with the applicable provisions of Federal and State laws, regulations and policies.

Contracts Section obtains written approval, from AHCCCS Contracts and Purchasing Office, of all types Administrative Services Subcontracts at least 30 days prior to the start date of the contract. These contracts include any delegated agreements, management services agreements and any service level agreements with any Division or Subsidiary of a corporate parent owner.

CHS submits copies of all Hospital contracts, including amendments, to AHCCCS, Division of Health Care Management.
Before entering into any type of administrative services subcontract, the subcontractor's ability to perform the activities to be delegated are evaluated by our Medical and Utilization Management Section (M/UM). The M/UM Manager reports the findings and reviews the evaluation data with the Contracts Section prior to entering into the subcontract.

Annually (within 90 days from the start of the contract year), the Contracts Section prepares and submits the Administrative Services Annual Subcontractor Assignment and Evaluation Report to AHCCCS, Office of Managed Care, detailing any Contractor duties that have been subcontracted as described under Administrative Services Subcontracts in Section 33 of the Contract with AHCCCS. The Report shall include:

- Subcontractor's name
- Delegated duties and responsibilities
- Most recent review date of the duties and responsibilities of the subcontractor & financial position of the subcontractor
- A comprehensive summary of the evaluation of the performance (operation and financial) of the subcontractor. The full report shall be made available upon request form AHCCCS.
- Next scheduled review date
- Identified areas of deficiency
- Corrective action plan(s) (as necessary

A merger, reorganization or change in ownership of an Administrative Service subcontract will be reported to AHCCCS for prior approval and requires a contract amendment.

In accordance with AHCCCS contract requirements, the Contracts Section will promptly inform AHCCCS, Division of Health Care Management, in writing if a subcontractor is in significant non-compliance that would affect their abilities to perform the duties and responsibilities of the subcontract.

All hospital and physician group subcontracts contain language for "Termination without Cause" that requires a 90 day notice prior to a contract termination.

Letters of Agreement are tendered in urgent situations or when the amount of services is estimated at less than 25 units per year or $50,000. At a minimum, Letters of Agreement include AHCCCS Minimum Subcontract Provisions, insurance requirements, and specifications regarding member care such as level of care, reimbursement agreement, duration of placement, acute medical service information including PCP data, emergency care and pharmacy information. In addition, the provider is required to forward all copies of current licensure and applicable certifications enabling them to provide the contracted service and a current copy of insurance certificate(s). The provider is also required to maintain Worker's Compensation and Unemployment Insurance as required by Arizona Law. The CHS Provider Manual is incorporated by reference into the document.

Formal contracts are negotiated for any and all providers anticipated to provide services more than 25 times per contract year. Exceptions to this requirement are as specified in Section 33 of the AHCCCS contract. Professional services (physicians, specialists, allied health professionals), hospitals, and sole source providers may be contracted without an RFP process as approved by the Director. All other contracts such as skilled nursing or assisted living facility services are tendered based on a competitive bid process in accordance with Cochise County Procurement Code and Program Contractor Policies and Procedures.

All sub-contracts comply with Federal and State laws, regulations and policies including but not limited to AHCCCS Minimum Subcontract Provisions and the criteria set forth in Section 33 Subcontracts of the AHCCCS contract. Subcontractors also receive a copy of the Cochise Health Systems Provider Manual that is incorporated by reference

into the subcontracts and includes specifications as required by AHCCCS. Provider Manuals are distributed once contracts are fully executed and awarded to the provider or upon request before the completion of the contracting process. The Provider Manual is updated quarterly on the CHS Website available at http://www.co.cochise.az.us/CASS/Doc/ProviderManual/Provider%20Manual%20White%20Pages.pdf, and subcontractors are notified of the changes via a one-two page mailer.

Subcontracts include provisions that providers/contractor agrees to provide, arrange for and coordinate all Medically Necessary Covered Services for Members, including Emergency Medical Services; twenty-four (24) hours a day, seven (7) days a week, including holidays. Sub-Contractor shall provide Covered Services to Members through office visits during regular office hours, after hours office visits, skilled nursing facility visits, home visits or other appropriate non-office visits such as emergency and inpatient.

Contract provisions also ensure that Sub-Contractors shall provide Covered Services to Members with the same standard of care, skill and diligence customarily used by similar physicians in the community in which such services are rendered and with the same availability as offered to other patients. The Sub-Contractor shall take all reasonable steps to insure that Agency clients shall in no manner whatsoever be discriminated against by the Contractor or any agents or employees of the Sub-Contractor. The Sub-Contractor shall respond immediately to any charges of discrimination.

Contract files, at a minimum, contain a current copy of the fully executed contract, any amendments, a current copy of the provider's certificate of insurance, ADHS license or Business license, other certifications and licensure specific to the contract/service type and any pertinent correspondence related to the contract.

On an annual basis, prior to contract amendment or award, Contracts staff reviews the comprehensive Provider Profile Summary, maintained by the Medical & Utilization Management Division. The Summary provides an overview of previous utilization outcomes, Quality of Care Issues and other information pertinent to the performance of any current contractor. In addition, the grievance files are reviewed to identify any potential contractual issues or quality of care issues when processing a contract amendment to determine if the provider is eligible for continued participation on the CHS network.

B. Provider Contracting and Monitoring Process

Number & types of Providers in service area:

The CHS has Network Summary demonstrates the large number of primary care providers, specialists and the full range of other contracted services that are available to our members. This also demonstrates that CHS has a network that is diverse and flexible and adequately meets the needs of our membership. The CHS Provider Directory is also available through our website http://cochise.az.gov/cassprovsearch.aspx. Within the past year, CHS has added approximately 84 credentialed providers whose services range from Primary Care to Neurology, Orthopedic Surgery, Plastic Surgery, Radiation Oncology, and Thoracic Surgery. This brings the total number of network physicians and allied health professionals to approximately 409 providers. CHS contracts with numerous providers in Cochise, Graham, Greenlee, Pima and Maricopa Counties to provide a range of services to our members. Providers are required (via Contract) to hire culturally competent staff and to provide appropriate staff for our Members needs. For detailed information on our Cultural Competency Program, please refer to the CHS Cultural Competency Plan also available on the CHS website. This is also an option on the Website Provider Directory and languages are listed as a search option. For example, you may input the following search criteria-Douglas PCP Spanish and the search engine would display PCP's in the Douglas area who speak Spanish.

Specific information regarding the status of each component of the network follows in the next section of this Plan.

Number of physicians with hospital privileges:

All primary care physicians and specialty physicians contracted with Cochise Health Systems have hospital privileges with the exception of two PCP groups in the Douglas area. They are Bisbee based groups and have privileges at Copper Queen Hospital in Bisbee. If a member is admitted to SAMC Hospital in Douglas, the admitting physician provides coverage during their inpatient stay and upon discharge the information is relayed back to the PCP. In addition, Case Managers contact the member to make sure the member has followed up with their PCP to discuss any changes with their health care needs such as changes with medication or a need for follow up laboratory services. The PCP located in Duncan, Arizona who is part of Canyonlands Community Health Care does not have privileges at Mt. Graham Regional Medical Center. There is no local hospital in the Greenlee area and patients are referred to Mt. Graham Regional Medical Center in Safford or routed to Tucson depending on the nature of the medical emergency. If one of the members assigned to these physicians is admitted to Mt. Graham, they are assigned to one of the local community physicians with hospital privileges at Mt Graham and this provider assumes responsibility for their care while the member is in the hospital. The assigned physician then coordinates any follow-up care with the member's Primary Care Physician.

Number of providers not accepting new patients:

At times Network Physicians may temporarily close their panels and are unable to accept new CHS members. This is often the result of a physician leaving the area and community physicians absorbing his/her panel of patients until a replacement is found. Once the new physician is credentialed, the panels are again opened to accept new CHS members. For this reason, CHS attempts to contract with all primary care physicians in the GSA. When instances such as this occur, CHS will temporarily credential any new physicians through the Medical Director to expedite the process and allow members to use new physicians right away to prevent any gap in service and to promote continuity of care. At the time a physician is temporarily credentialed, the full/formal credentialing process is initiated. Once the file is completed, the credentialing committee reviews the physician's file for regular/full credentialing status. Temporary credentialing is only valid for a period of six months.

Professional Services

Professional service providers are selected based on geographic location in conjunction with recommendations made by Primary Care Physicians and other healthcare professionals, the CHS Medical Director and the Peer Review and Credentialing Committee. Ideally, CHS awards contracts to all physician providers willing to provider services to CHS Members in each city of the GSA unless determined non-eligible by the CHS Peer Review/Credentialing Committee. Awarding to multiple medical providers in each city in the GSA helps CHS to shape a network that is diverse and flexible to meet a variety of member needs from immediate to long range care needs and gives members the option to choose a provider and to change providers should they elect to do so. In addition to awarding contracts within the GSA, CHS also contracts with providers out of county, primarily in Pima County, to prevent any service gaps in the network and also to expand the network of providers for our members. This may include contracts with additional nursing facilities and assisted living homes in Pima County whose specialty is behavioral management. In Maricopa County CHS secures letters of agreement with various skilled nursing facilities when our network cannot meet the needs of members with special health care needs.

Selection of specialists practicing outside the geographic service area is also contingent upon particular service requirements such as (but is not limited to) the AHCCCS minimum network standards, medical needs of our membership and the location of service provision. CHS emphasizes contracting not only with in-county specialists, but also out of county specialists who maintain service sites in any city within the geographic service area. Member appointments are scheduled whenever possible during the in-county office hours unless medically contra-indicated.

Professional service procurement is also a collaborative effort of the health care professionals in each of the communities located in the GSA. CHS helps to identify potential areas of service for primary and specialty providers

based on current member needs, demographics, acuity and projected growth. The health care professionals recruit within their own organization based on our information and that of the surrounding communities (demographics, growth, acuity, etc...). In turn, Contracted providers also help to build our network through their own recruitment efforts with their organization and the community.

Non-Professional Services

Non-professional services are also selected on the basis of geographic location and recruitment is based on applicable state and federal regulations, AHCCCS policy and the Cochise County Procurement Code. All providers must, at a minimum, have in effect current licensure for the contracted service, meet minimum insurance requirements and provide services in accordance with the service specifications of the Request for Proposal (RFP) and contract. CHS awards to multiple providers, whenever available, in each city of the GSA to prevent any limitations or deficiencies and to provide members with a strong network of providers from which to choose.

CHS also recognizes the diversity of our membership and therefore selects providers, whenever possible, with diverse linguistic skills to expand network options and to ensure that members receive care that is culturally and linguistically sensitive. For professional service providers, information regarding linguistic skills is gathered from the credentialing application. Non-professional provider information is compiled from the request for proposal and interviews with management regarding their personnel. Interpreter services are also available to all providers. CHS contracts with InterpreTalk, a company that offers phone services that facilitate communication with non-English speakers. This service is available 24 hours a day, 7 days a week. This information is available to provider through a variety of mechanisms such as; the Provider Manual, Provider Newsletter, Website, quarterly provider manual updates and on-site monitoring.
The RFP process is another mechanism used as discussion platform that helps CHS determine a bidders' ability to deliver services in a manner consistent with the philosophy of CHS and in addition promotes competitive bidding between the providers and contains cost for CHS while offer quality care to our membership. Other factors considered during the RFP process include current populations served, potential growth based on past expansions of services, and projected populations, including development of specialized services, e.g., a nursing facility in Cochise County with the growth potential for a behavioral unit, a home health or assisted living provider expanding into transportation services for members in their care.

In addition to awarding to multiple providers, Cochise Health Systems also actively pursues contracts with providers (both professional and non-professional services) in a variety of areas for members whose needs are not within the scope of the minimum network standards, such as members with highly specialized needs or rare diagnoses. CHS consults with the Medical Director and members of the Cochise Health Systems Quality/Utilization Improvement Committee and Network Task Force for input regarding potential providers. CHS also consults with other ALTCS plans and providers and contacts current sub-contractors from the Network for possible suggestions of potential providers to find appropriate specialized settings. Examples include contracts with facilities that have units for young members.

Provider Monitoring

The Contracts Section, in coordination with the Medical & Utilization Management Section, conducts on-site facility reviews for new contractors within the first 120 days of operation. It is the philosophy of CHS to build strong relationships and communication lines with our providers by personally expressing an interest in their operations rather than being just a voice on the phone. The initial visit and training with new contractors is used to ensure that providers understand the program and the various rules and regulations that apply to it. The training varies based on the contracted service with special focus on claims, authorization requirements, specifications, contacts with CHS, Provider Manual and how to use it, the Formulary (if applicable), and provider network responsibilities for specifically communicating with other providers in the delivery of care. Training for provider staff members that are specifically related to topics such as, fraud and abuse, cultural sensitivity, elder care, gaps in services (Ball vs.

Betlach) and behavioral health services are reviewed for contractual compliance. CHS also uses this time to probe the provider for any input regarding our services such as coordination of care with other providers, availability of providers to meet members' service needs (either themselves or others), and suggestions for new providers for the network.

On-site facility assessments are conducted for all contracted providers once a year or every three years to ensure compliance with AHCCCS and CHS contractual requirements. HCBS providers, Skilled Nursing Facilities, Assisted Living Facilities and other providers are monitored on an annual basis in accordance with AHCCCS policy 920 of the AMPM. Monitoring assessments include (but are not limited to) a site review, review of providers policies and procedures including policies on drug screening, fraud/abuse, federal false claims act, emergency protocols and personnel records (on selected providers), verification of current licensure and most recent State survey results in relation to the contracted service, and verification of CHS provider manual maintenance. In addition providers are internal surveyed by the surveyor for any grievances, claim disputes, quality of care concerns and other internal data that may be relevant. Any changes regarding contractual or program requirements are also conveyed during the monitoring visits. Again, communication is encouraged with our providers. If additional questions or comments arise after our visit, we ask providers to contact us at any time, especially as problems arise and not months later. If issues with other sections of CHS are identified during the monitoring visit, contracts staff refers the information to the appropriate staff member for action or resolution. This manner of communication with our providers also assists CHS in the development of training sessions with our providers by identifying areas of concern or confusion.

During monitoring Contractors are surveyed to ensure they have the ability to accommodate members with different ethnic backgrounds, such as bilingual staff or intake forms in different languages. CHS also views provider monitoring as a tool to promote cultural awareness. On-site reviews are used to identify communication barriers with members and possible means of resolution. This may include the use of other more appropriate providers with diverse linguistic skills and cultural understanding or the use of translation services available to CHS members and providers.

If a need for improvement is noted during a monitoring assessment, the Contracts Section requests specific plans for improvement from the provider. Needs for improvement that are quality of care concerns are forwarded to the Medical & Utilization Management Section who then works with the Contractor to develop a plan of correction. The Contractor is then specifically monitored for compliance according to their plan of correction. Results of the reviews are forwarded to the provider. Individual survey forms and subsequent documentation is filed in the Provider Monitoring File and Provider Contract File.

If issues are identified prior to the monitoring visit as something problematic, it is addressed personally in the visit to ensure the provider understands and is able to comply with the requirement. Internal communications with CHS staff members are often used as a method to identify providers experiencing problems or difficulties that may range from coordination of services to claims submission. Issues raised by a specific provider in a monitoring visit may be addressed with similar providers in future visits to ensure that what was a problem for one is not a problem for all. The resolution to these problems would then be disseminated via provider group specific mailings, followed up by changes in policy, the Provider Manual or contracts, as necessary. Providers are encouraged to contact the CHS Administrative Office with questions or concerns. They are made aware of their grievance and hearing rights in a variety of ways, including the Provider Manual, their contract and statements provided with remittance advice with claims that have been denied.

Provider Network Summary

CHS provides the Network Summary Report twice a year due October 15th and April 15th. Bi-annual submissions of the network summary shall comply with the specifications set forth in the AHCCCS Contract and the ALTCS Provider Network Summary instruction memo dated October 22, 2001.

COCHISE HEALTH SYSTEMS
NETWORK DEVELOPMENT AND MANAGEMENT PLAN
NOVEMBER 15, 2010

Part II – CHS Network and Management Plan

1. Evaluation of the prior year's Plan including reference to the success of proposed interventions and/or the need for re-evaluation:

The contract period of October 1, 2009 to September 30, 2010 was another successful year for CHS in terms of network development. Almost every type of service has expanded enabling us to accommodate for membership growth and offer choice to our members. CHS would like to identify that all providers and members were notified of the Adult Benefit Changes effective 10-1-10. CHS sent out provider and member newsletters and amended both the provider manual (including policies) and member handbook. These are available on our website for reference.

This year some exciting events have occurred for Cochise Health Systems. Historically it has been a challenge to contract with either a plastic surgeon or neurosurgeon and this year we were able to add Arizona Community Surgeons PC. This group has five physicians contract thus far and one PA-C. One doctor is a plastic surgeon; two others specialize in oncology while another is a thoracic surgeon. CHS also added Center for Neurosciences to the network bringing at least 18 physicians of different sub-specialties in neurology. These subspecialties are Adult and Pediatric Neurology, Neurosurgery, Neuro-Oncology and Interventional Pain Management.

In addition to these groups CHS added The Pain Institute of Southern Arizona and Tucson Vascular Surgery. CHS has had many requests for pain management specialist and the addition of the group was an asset to our network in terms of meeting our members' needs. The vascular surgery group was important as many members preferred this provider and would have to transition from Dr. Berman to another network vascular surgeon. CHS was finally able to contract and thus allow greater flexibility within the network. Overall, CHS has added many new providers of different disciplines to allow for flexibility and diversity for our membership.

<u>**Evaluation Process of the current status of the Network**</u>

Through monitoring and various input processes, such as member and provider surveys, member assessments, Member and Provider Expressions of Dissatisfaction, Grievance and Appeals process, Quality of Care Concerns, Physician Accessibility Surveys, and CHS Quality Circles. CHS evaluates the network on an ongoing basis. Quality Circles are a fairly new mechanism developed and implemented by the Director in 2008. In addition to this, CHS has other groups that meet that help us evaluate the status of the network. This process allows for the continuous communication of information between all CHS Divisions Outcomes. Circles meet every two weeks to one a month and topics range from member care, to provider issues, pended encounters problems or communication issues between divisions (not an all inclusive list only a suggestive sampling of topics addressed). One action log is keep to avoid duplicative efforts (same topics in many circles) and notify all divisions of issues that pertain to us all. Outcomes of all these evaluation mechanisms determine specific goals for the future. One other group that has emerged is the Inter Rater Group that identifies services that may trend based on Health Information System reporting. For example, CHS may review the High Utilization report and make recommendations based on the finds of the report as applicable. This report or others generated from our Health Information System could identify possible trends with particular providers. This group may also review a particular service such as DME to determine if members' needs are being meet. As an example this group identified that member supplies were being delivered even when the members were not at home due to hospitalizations. The DME Company would have the supply orders generated each month and drop ship to the members home or the group identified that some members did not use the supplies they received but never voiced this so the supplies kept coming each month. Now as a result of these findings case managers evaluate the DME services each assessment to ensure that members' needs are being met. Minutes from the group are available upon request

The geographic service area that includes Cochise, Graham and Greenlee counties is a vast rural area with great cultural diversity. As such, contractual performance for both program contractor and subcontractor is hindered by the hundreds of miles that separate the GSA from the rural and urban communities and the special cultural needs that may vary by community. To prevent any inadequacies within the provider network and to prevent any risk to member

care, CHS maintains close relations with providers and members to ensure that we are aware of issues that could compromise continuous coverage, such as our members who may want another provider or a provider who goes out of business.

2. Current status of the network by service type (Hospital, Nursing Facility, HCBS, Primary Care OB/GYN, Specialist, Oral Health, Non-Emergent Transportation, Ancillary Services, etc.) at all levels including:

a. how members access the system b. relationships between the various levels (e.g. PCP, Specialists, Hospitals)

This section identifies the current status of the CHS Provider Network, CHS has included as an attachment, the CHS Provider Network that demonstrates the large number of primary care providers, specialists and various services that are available to our members. The CHS Network is also available through our website at www.co.cochise.az.us/CASS/CHS.htm

Long Term Care
The Network requirement for Skilled Nursing Facilities requires five SNFs in Cochise County, one in Graham County and one SNF within one hours drive in Greenlee County. Currently, CHS has contracts with all six nursing facilities between Cochise and Graham County. In the Benson and Willcox areas of Cochise County, CHS has also contracted with the two Hospitals for Swing Bed services. In addition to this, CHS maintains contract with eight SNFs in Pima County and this year has added Scottsdale Village Square in Maricopa County and maintains a letter of agreement with Desert Haven (sister facility to Santa Rosa Care Center in Tucson) for members whose needs cannot be met within the contracted network. This brings the total to fifteen SNFs in the CHS network and 2 Swing Bed Facilties

HCBS Community
Assisted Living Facilities—The CHS Network is comprised of 20 Assisted Living Facilities; 14 in Cochise County, 2 in Pima County and 4 in Graham County. There are no ALF in Greenlee County.

Behavioral Health Facilities-Six of the Assisted Living Facilities in Cochise County are contracted for behavioral health services and two in Pima are contract for Behavioral services. In addition the two Phoenix based SNFs also provide behavioral health services for CHS. CHS is contracted with Intermountain of Tucson who runs a variety of different homes and and offers a variety of behavioral health services in the Tucson area. Blake Foundation provides Behavioral Management services in Cochise, Graham and Pima Counties.

HCBS Home-There are now four Medicare Certified Home Health Agencies contracted in Cochise County and three Non-Medicare Agencies and 11 Direct Care agencies who provide a range of services from Attendant Care, Homemaker services and Respite services (three of these agencies provide both nursing and paraprofessional/direct care services). Catholic Community Services (HHA) and Douglas ARC provide home delivered meals throughout Cochise County. In Graham County, one Medicare Certified Home Health Agency is contracted to provide nursing, therapy home delivered meals and non-skilled or direct care services such as Attendant Care. Another agency is contracted to provide direct care services including attendant care, homemaker and personal care services. Both of these agencies cover Graham, Greenlee and the northern part of Cochise County.

Emergency Alert Services are provided by Life Line and covers all counties for Cochise Health Systems. This year CHS released a bid for Emergency Alert Services and has expanded the network to include an additional provider. This provider is: Critical signal tech "your link to life" who offered more competitive rates and this changes also offers choice to our members.

Habilitation services are provided by the Intermountain, Easter Seals Blake Foundation, Douglas ARC and Graham County ARC. In addition, the Blake Foundation offer habilitation services in Graham County. ABRio Family Services and Supports is a newer contracted provider for CHS who offers direct care services and also provider Habilitation services in both Cochise and Graham Counties.

Behavioral Health Facilities—CHS hold contracts with Hospitals, Skilled Nursing Facilities and Assisted Living Facilities to meet this network requirement. In addition, the network offers multiple outpatient services through SEABHS within the GSA. There are also independent counselors, psychologists, psychiatrists and psychiatric nurse practitioners contracted who offer services in Cochise, Graham, Greenlee and Pima County. CHS has made contact with the new RHBA, Cenpatico, and will seek contracts with the new providers the RHBA intends to introduce into our GSA. This will take effect in December. The RHBA will provide oversight and offer additional providers. CHS expects to expand the network by the new-year including a mobile crisis unit that is available to anyone in the GSA. Update 2011-CHS has secured agreements with two of Cenpatico outpatient providers who have initiated services in our GSA. This continues to be a work in progress as the providers finalize ADHS surveys, obtain licensure and register with AHCCCS.

Acute Services—
Dental Services-The Adult Benefit changes effective 10-01-10 have eliminated Emergency adult dental services. However, CHs will follow the guidelines set forth by AHCCCS and in accordance with federal law and the State Plan. This states that AHCCCS will cover medical and surgical services furnished by a dentist only to the extent that such services may be performed under State law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician. For members 21 years of age and older, the services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. The covered services include examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Certain pre-transplant services (e.g. dental cleanings, fillings, restorations, extractions) and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head are also covered. All dental providers have been notified of the Adult Benefit Changes via the Provider Newsletter and CHS polices have been revised as well.

Inpatient and Outpatient Hospital-Nine hospitals are contracted to deliver both inpatient and outpatient services, including laboratory, radiology-including mammography, x-ray, CAT scan, bone density scan, ultrasound, and open MRIs, telemedicine & tele-trauma and therapy services and much more. Each hospital maintains their own website that details what services they provide. CHS can comfortably state that the network is both diverse and flexible and meets an array of members needs for both inpatient and outpatient services.

DME services are delivered through four contracted DME providers who provide services in Cochise, Graham, Greenlee and Pima counties. CHS had just completed the bidding process for DME services last year and added one new provider in the Graham County area. This year another bid was released with the intent on finding additional resources for custom products. We are please to state that we were able to secure a contract with United Seating and Mobility and have already observed a benefit to adding this provider to the network.

Pharmacy services-CHS has at least ten different pharmacies to deliver services within the geographic service area for covered services (with consideration to Medicare D and the Medicare Modernization Act). One pharmacy has multiple locations in Arizona; two in Cochise and a multiple sites in Pima County, the service sites have been reduced over this last contract year due to budget issues and the pharmacy is currently in Chapter 11 Bankruptcy. This has affected CHS in one area where the pharmacy was procured by another vendor within the network. This transition was seamless to the members. CHS chose to add the Pima County Pharmacy sites to assist members when discharged from a Tucson hospital over a weekend or at night. There is now more than one provider in some areas of Cochise County to offer choice to our member. Douglas and Sierra Vista areas of Cochise County, as an example, have two pharmacies that provide services to HCBS members.

Foot and Ankle Services-this is another benefit change for member and providers effective 10-01-10. CHS has amended manuals and policies to reflect these changes and have notified both providers and members of the changes. There is also a link to our website. Services shall be covered as outlined in the AHCCCS AMPM.

Physician Specialist services range from Allergist to OB/GYN to Urology and most everything in between. Most specialists are contracted from Pima County but have satellite locations throughout Cochise County or in Safford. If no clinic is available within the GSA, members are transported to Pima County for services. Services also extend into Maricopa County as deemed necessary. As previously mentioned CHS has added some new specialties to the network in the areas of pain management and neurology.

Therapies are available to members through contracted hospitals and skilled nursing facilities who offer outpatient therapies. In addition, one home health agency in Graham County offers services and a few independent providers are contracted for OT, ST and PT services. Within this next contract year, one HHA in Cochise county may offer therapy services as well.

Non-emergency transportation is available to members through nine different transport providers in all areas of the GSA and includes regular and after hours services. Any one of the available ambulance (including air transport) providers in the GSA renders emergent transport services.

(a & b) How members access services and relationships among the various levels:

On an annual basis, CHS prepares a member handbook in English and Spanish that welcomes members to the Cochise Health System. The handbook outlines the ways members can access services. It explains in detail that a Case Manager is assigned to the member and is the member's one-on-one contact for assistance with the program. It explains the role of the Case Manager, the service plan developed for the member, services available, describes how to choose a doctor, how to change to another doctor, how to schedule an appointment, emergency services, pharmacy services, etc. In addition to mailing a copy to each of our members, the member handbook is available on our website @ www.co.cochise.az.us/CASS/CHS.htm. This year the member handbook was revised to include the AHCCCS Adult Benefit Changes effective 10-01-10 and is already posted to the website.

The member newsletter is another resource for members and provides information on how to access services. This newsletter is published twice a year and includes educational information, reminders on flu shots and other prevention measures. The most recent newsletter included information an article from our Medical Director on Immunizations/Vaccines. The publication also included information on the Adult Benefit Changes, Cultural Competency and Medicare D Information. The spring newsletter included an article on Diabetic Care, HIV/AIDS and pregnancy testing and fraud and abuse. This newsletter is mailed out bi-annually to members, is available in Spanish and is also available on the Cochise County website. All member communications are in accordance with applicable state and federal regulations and AHCCCS policy such as the AHCCCS ACOM Member Communications Policy. For additional information please refer to the CHS Cultural Competency Plan available on our website.

Case Management and member access to services. The case manager meets with the member and/or family within the first ten days the member comes on to the Program. A list of PCP providers is given to the member who makes a choice of which PCP he/she wishes to be assigned. An assessment is made to decide what services are required to meet the member's medical needs. The Case Manager develops a service plan, explains what services are available based on the needs of the member and arranges for services such as Skilled Nursing Home, Assisted Living, or Home and Community Based Services (home delivered meals or homemaker services). For those members receiving HCBS services, a Backup Plan is developed at the time of initial assessment to prevent any gaps in HCB services (refer to the semi-annual Ball v Betlach reports for further details on Contingency Plans and statistical analysis submitted to AHCCCS).

Members who live at home are able to schedule their own appointments with their PCP and may contact their Case Manager if they require assistance. If they reside in a Nursing Home, the PCP provides regular visits at the facility. The Nursing Home staff can contact the PCP to arrange a visit if required outside the normally scheduled visit. The

PCP is responsible for all health care and will make referrals for specialty services when needed. If a member resides in an Assisted Living Facility (ALF), the ALF will schedule appoints on behalf of the member.

The CHS provider directory on the Cochise County website is another mechanism both members and providers may access the system. This network is now available as a searchable directory. Users may look up a provider by name, address, zip code, specialty, and provider type (name not the number—for example Hospital). The network is revised and mailed out quarterly to providers. Members receive a copy of the network via the handbook revisions that are mailed out each year. This network includes; PCPs, Specialists, Hospitals, Pharmacies, SNF and Alternative Residential providers.

Access of members to Specialty Services- the Case Manager works closely with the member, the PCP, the Prior Authorization Section of Medical Management and the Contracts Section when the need for Specialty Services is identified. The member's PCP will make referrals for specialist visits/services, unless otherwise stated in policy or as set forth by AHCCCS including the Benefit Changes effective 10/1/10. The Case Manager works closely with the Prior Authorization Department to ensure the timely referral for specialty services. Specialty services required outside of the CHS network are coordinated between the Prior Authorization department and Contracts Department. If this occurs services may be managed through a Letter Agreement (LOA) (as deemed necessary) with the provider for temporary service until a formal contract can be arranged, if necessary.

Selection of specialists practicing outside the geographic service area is contingent upon certain service requirements, such as minimum network standards, medical necessity for members and the service location. CHS emphasizes contracting not only with in-county specialists, but also out of county specialists who maintain service sites in any city within the geographic service area. Member appointments are scheduled whenever possible during the in-county office hours unless medically contra-indicated.

3. Current network gaps and the methodology used to identify them

Network gaps are captured through a variety of mechanisms here at CHS. This includes; daily contact with Case Management, Providers, and Prior Authorization Staff help Contracts Staff identify deficiencies and arrange services through short form contracts or letters of agreement until a formal contract is in place. Other mechanisms include; Quality of Care Concerns, Expressions of Dissatisfaction, Quality Circles, Provider Monitoring, Provider/Member Surveys, bi-annual submission of the network summary that involves the periodic evaluation of the network, CHS Inter-rater Reliability Group and Provider/Member Council Meetings as well as other subgroups (a DME and HCB services work committees) that may work on specific services with the goal of improving and streamlining our workflow to best meet members' needs.. As an example, a member with high acuity behavioral health needs was identified and required placement at a facility who could manage her needs. CHS secured a Letter of Agreement with a SNF in Maricopa County for a rate slightly above the negotiated rate with a Tucson network provider who provides behavioral health services. This in turn led to a formal contract with the provider where two members are now placed. Maricopa is not within our own GSA, having a SNF particularly for behavioral health services is a most excellent addition to our network given the complexities of some cases we are challenged with.

Acute Care Services:

Hospital Services

CHS is contracted with five local hospitals in Cochise County, one hospital in Graham County and three hospitals in Tucson. The local hospitals are not tertiary care facilities and any members requiring tertiary care are transported (based on their acuity) via contracted ground ambulance or via air to one of the contracted tertiary care facilities in Tucson. In cases were these facilities are on divert, the member is transported to the closest medical facility capable of meeting the members needs that has available beds.

COCHISE HEALTH SYSTEMS
NETWORK DEVELOPMENT AND MANAGEMENT PLAN
NOVEMBER 15, 2010

Primary Care Physician Services

While CHS contracts with most Primary Care Providers in our geographic service areas, closed panels are an occasional and temporary issue we are faced with. Last year there were approximately 37 Primary Care Providers available to members this year there are 49 PCPs available to members in the GSA.

Last year M.D. Med Inc. closed their practice offices in Sierra Vista. This medical group offered a range of Primary Care and Specialty services and the closing came as quite a shock to the community and the providers themselves. Most of the providers within this organization were hired by other healthcare providers in the Sierra Vista area and one Primary Care provider was able to open his own private practice within two months and continued to attend to patients in SNF and ALF settings. This provider has now expanded his services to a Tombstone clinic and also is a consulting physician for CHS.

CHS continues to struggle with Primary Care Providers in the Douglas area of Cochise County. This year however, we were able to add one new physician and two allied health professionals. At this time if members are unable to secure appointments with providers in the Douglas area, they are transported to the Elfrida Clinic or Bisbee sites for services. The Bisbee PCP network has up to 15 doctors now and also added some allied health professionals. This group also rotates in the Elfrida clinic.

In Graham County, the Primary Care network has gained three new PCP's bringing the total number of doctors to 9. This is quite a benefit given the circumstances and losses last reporting period.

Ancillary Services, Specialists, Lab/XRay, Therapies, Pharmacy

There are no gaps in service for Ancillary services. Although there is no minimum network standard by specialist type, CHS did not have a contract with a neurological group as of last year. We are happy to report that CHS was able to secure a contract with Centre for Neurosciences. CHS continues to pursue a contract with UPH and has hopes of securing a multi-discipline contract including Specialist, Hospital Inpatient and Outpatient Services and Primary Source Verification for only their group of practitioners.

Home & Community Based Services:

In-home services

CHS provides a full range of HCB services from skilled nursing to attendant care, personal care, housekeeping and home delivered meals. There are a total of 18 HCB providers in GSA with one provider located in three different service sites in Cochise County. This year Sunlife was certified by Medicare for Home Health Services and will now only offer this service to CHS. One agency opted not to renew their contract however this has no impact on the network and there are no gaps in the network for this service type.

Adult Day Health/Group Respite

Neither Adult Day Health nor Group Respite services are available in Cochise, Graham or Greenlee Counties. The limited availability or lack of this service is a function of having many small communities scattered over almost 13,000 square miles and not enough potential members in any one area to financially support these programs. **The short-term resolution** is that members whose families need respite are offered in-facility or in-home respite services in lieu of Adult Day Health or Group Respite. The approach toward **long-term resolution** is to continue to identify any potential contractors who may wish to provide this service, including existing or new providers. ****2011 Update-** Adult Day Health (ADH) Services are listed in this document as a network gap based on the lack of ADHS licensed ADH providers in Cochise, Graham or Greenlee Counties. Recently, CHS received a Letter of Intent (LOI) from Abrio Family Services for Adult Day Health Services. With this LOI, it is our mutual goal to expand services to our

geographic services areas. This will be a work in progress and CHS will report our developments/accomplishments with the next Network Development Plan. CHS has also reached out to Graham County ARC and Douglas ARC with the same goals.

Home Modifications Members' needs for home modifications are met in accordance with CHS Case Management/Contracts policy on home modifications. Briefly, CHS sends out a Request for Quotation for each home modification and awards to the lowest and most responsive bidder for that project. Services are obtained and provided in accordance with AHCCCS policy. CHS continues to seek additional contractors via requests for quotations from providers who have active AHCCCS ID numbers. Through this process we were able to add Ameri-Fab out of Tucson Arizona to our network of licensed contractors. In 2008, Ameri-Fab expanded their services to include home modifications such as bathroom modifications. There continues to be significant limitations in the number of quality contractors available for provision of this service. Mostly, the providers are inundated with other work that prevents them from seeking additional business with CHS. The providers that do respond to requests for quotation either cannot meet our deadlines because they are too busy or the expansive rural area and distance to location are time and cost prohibitive to the contractor. The result is bids submitted that are very high. The **short-term resolution** has been to accept the most responsive bid (even if not the lowest) in order to ensure the provision of service. The approach toward **long- term resolution** to this problem will be to continue to increase the number of interested contractors who are AHCCCS-approved in order to create a more competitive market. At this time, both Hodges Glass and AmeriFab are able to meet the needs of our members. The service area for both Hodges and Ameri-Fab include Graham and Greenlee Counties. One additional **long-term goal** that was recently identified as a potential solution is the collaboration between departments within the County. The County has a facilities department that meets the building modifications for each area of the county from Bisbee to Willcox and one of the CHS employees has written this up as a proposal to the County Administrator for consideration. This may not come to fruition for years to come but is certainly a viable option we intend to explore. Update—this was submitted as a proposal to the County Administration however it was not approved.

Institutional Services While CHS meets all Minimum Subcontract Requirements for skilled nursing facility services, all available providers are at least 90% capacity and occasionally maintain waiting lists. In addition, there are no facilities in Cochise, Graham or Greenlee Counties that specialize in behavioral health. Therefore, CHS contracts with a multitude of facilities in the Pima County area to prevent any gaps in service. CHS has contracted with eight facilities in the Tucson area bringing the number of Skilled Nursing Facilities in the Network to sixteen (this number includes two swing bed facilities one in Benson and one in Willcox), seven of which have Behavioral Health Management Units. In addition, this year CHS added a contract with Scottsdale Village Square in Maricopa County who also provider behavioral management services and have option (whenever availability allows) for the negotiation of Letters of Agreements with facilities such as Ridgecrest or Desert Haven in Maricopa when deemed necessary. Our network structure to include Pima and Maricopa County SNFs ensures member placement if local facilities are temporarily full, and prevents any gaps in service. This also serves to provide options particularly for members with highly specialized needs, behavioral problems, or rare diagnoses. These additions will also ensure continuity of care should any of the contracted facilities in the GSA abruptly discontinue services.

For short-term resolutions (specifically for members on a waiting list or members with specialized needs) CHS will continue to use Letter of Agreements for facilities that do not have existing contracts. These agreements will cover members who roll onto the program until they can be placed in a Network facility and in cases where the member may have unique Behavioral Health needs. The approach toward long-term resolution will be to contract with behavioral health providers within our GSA as they become available and to assist existing facilities with expansion projects for behavioral health as they emerge.
*The Administrator of Quiburi Mission, contact me recently to announce their intention to expand services for a secured Behavioral Health Unit. The CHS Director has proved a letter of support and we have provided other documentation to assist in their preparation of this unit such as current reimbursement levels so they may efficiently estimate cost of this undertaking. The Administrator feels confident that they will receive the funding to launch this project. This is exciting

new for CHS as most of our members are relocated to Pima and Maricopa when in need of SNF Behavioral Health Services.

***Update on Behavioral Health Facility for Benson**—Quiburi Mission in Benson Arizona now is offering services in their new special care unit. This unit is specifically tailored for more of our wandering dementia or Alzheimer's patients

HCBS Community / Alternative Residential:

Assisted Living Facilities

Approximately one hundred and one members reside in twenty contracted Assisted Living Facilities scattered throughout all the Cochise, Graham and Pima Counties. The Minimum Network Standards specifies three Assisted Living Facilities in the Graham/Greenlee County Networks (combine). This is no longer considered a gap. At one point there were only two ALH's available in Graham county however, currently CHS has four homes available to members.

Habilitation

Currently CHS has Letters of Agreement with Graham County ARC and Douglas ARC for habilitation services. In Cochise County there are agencies offering services in Sierra Vista (AIRES) and Bisbee (CPES) that we will contract with if needed. The Blake Foundation and Intermountain Centers also offers habilitation services within the GSA (except Greenlee) and also in Pima County. Greenlee County has no habilitation services available, therefore members are transported into Graham County for services. CHS added a HCB provider, ABRio Family Services and Supports who also offers habilitation services in Cochise County.

CHS continues to assess the need to expand the different types of habilitation services available. These habilitation providers offer a range of services including day treatment, DD group home service, and outpatient services in conjunction with a therapeutic residential setting. The **short and long-term resolution** has been to maintain a list of providers available in each area of Cochise, Graham and Greenlee Counties and negotiate the provision of services, with a Letter of Agreement, as member needs arise.

4. Immediate short-term interventions when a gap occurs including expedited or temporary credentialing

The Network is continually monitored for compliance with standard requirements. Any deficiencies or gaps/limitations are temporarily resolved with letter agreements while the formal contracting process is completed. Identified Network deficiencies considered material changes are relayed to AHCCCS in advance of the anticipated change and any unexpected major network changes are reported to AHCCCS within one day of the change.

Contracts Policy CON019 (based on AHCCC Policy), details the procedures for temporary credentialing of PCP and Specialty physicians. This status allows all privileges of regular status and provides time for an otherwise qualified and accepted medical provider to complete the process of obtaining current board certification or indication of Board eligibility or to obtain other information not found in the file. Provisional/Temporary Appointment will be awarded to the medical provider within 14 days of the initiation of the process. Full Credentialing of the medical provider will be completed within six months. Providers who fail to submit a complete credential file within six months are terminated from the CHS Network. Temporary credentials are valid for six months and are tracked through our temporary credentialing log. For consideration of temporary or provisional credentialing, at a minimum, a provider must complete a signed application. This includes:

- reasons for any inability to perform the essential functions of the position, with or without accommodation;
- no evidence of illegal drug use;
- history of loss of license and/or felony convictions;
- history of loss or limitation of privileges or disciplinary action;
- current malpractice insurance coverage;

- attestation by the applicant of the correctness and completeness of the application;
- work history for past five years;
- current DEA, AZ License, AHCCCS ID and NPI, NPDP query and validation that the provider has not been debarred, suspended or otherwise excluded from federal procurement activity.

Long-term contracts are awarded based on type of service to meet minimum requirements for covered services and network standards. Wherever possible multiple providers are awarded contracts for each service in order to ensure continuity of care, prevent any network gaps and to provide members with a choice of providers.

5. Interventions to fill network gaps and barriers to those interventions

Interventions

As stated previously, within the past year, CHS has added approximately 84 credentialed providers whose services range from Primary Care to Neurology, Orthopedic Surgery, Plastic Surgery, Radiation Oncology, and Thoracic Surgery. This brings the total number of network physicians and allied health professionals to approximately 409 providers. CHS contracts with numerous providers in Cochise, Graham, Greenlee and Pima Counties to provide a range of services to our members. CHS maintains a comprehensive network of Providers that exceed the minimum network requirements and enters into letter agreements to provide services not available within our formal Network until a contract is awarded through the procurement process.

Specific Interventions:

Gap-PCP- Graham County area; CHS temporarily credentialed 3 primary care providers bring the total number of doctors to 9 in the area for approximately 134 members.

Douglas area—The PCP network of Douglas is in a continual status of flux as provider come and go. This year CHS was able to add 1 new PCP and 3 allied health professionals. This brings the total number of physicians in Douglas to 9 (two of which are Pediatricians). If members' needs cannot be met in Douglas they are transported to either Elfrida or Bisbee clinic sites for services.

Gap—High Acuity Behavioral Health Facility—this contract year, one member required High Acuity BH services that could not be met through the existing network. CHS secured a contract with Scottsdale Village Square and Maryland Gardens in Maricopa County. Following this, CHS was able to expand the network and secured a formal agreement with the provider. CHS also expanded services for this member to include a psychiatrist that CHS has contracted and credentialed.

Gap— As previously mentioned CHS was able to secure an agreement with Centre for Neurosciences and Arizona Community Surgeons. These two groups bring a variety of different disciplines to the network expanding to meet the needs of our membership.

Gap—DME-CHS secured a formal contract with United Seating and Mobility to expand the network for custom DME services to ensure continuity of care and help improve the delivery of services to our members. CHS recently held an orientation with the provider and the subsequent feedback from our DME authorization specialist has been very positive.

Barriers

Gap—there are very few providers who offer services to the residents of Greenlee County. Generally, their needs are met through the network in Graham County. CHS has attempted to secure a contract with Gila Health Resources in Morenci who operates an urgent care clinic and offers outpatient services such as laboratory, radiology, therapies and

also has a full staff of primary care providers. The barrier is that the mine privately owns this area and the facility belongs to the mining corporation. This contract year, CHS sent an email to the mining corporation requesting a contract and was subsequently contacted by a representative from Gila Health Resources who requested another copy of the contract that he would share with the Medical Director. Periodic calls are made to the representative in hopes of securing a contract however, there has been no progress to date. In the interim of a contract, CHS does approve services on a non-contracted basis when medically indicated for members in the Greenlee County area. Currently the only services available in Greenlee County are pharmacy, in-home services and one PCP in the Duncan area. Member needs are met through the Graham County network that is available within a one hour drive from Morenci.

Update—Gila Health Resources has agreed to only provide Urgent Care services to our membership (24-currently) members. This is still under negotiation.

In addition, there is no local hospital in the Greenlee area and patients are referred to Mt. Graham Regional Medical Center in Safford. PCPs in the Greenlee area do not have hospital privileges at Mr. Graham. If one of the member's assigned to these physicians is admitted to Mt. Graham they are assigned to one of the local community physicians who have privileges at the hospital and assumes responsibility for their care while the member is in the hospital. The assigned physician then coordinates any follow-up care with the member's Primary Care Physician.

At times, contracted Network Physicians may temporarily close their panels and are unable to accept new members. This is often the result of a physician reaching panel capacity or a physician leaving the area and community physicians absorbing his panel of patients until a replacement is found. Once a new physician is credentialed and added to the network for that area, members may choose to continue services with the existing physician or select the new physician. CHS attempts to contract with primary care physicians in the all areas of our GSA to prevent any gaps when a physician leaves or closes a panel.

Infusion Therapy—CHS would like to reiterate the barriers experienced with Infusion Therapy Services—Last year we wrote...CHS has experienced issues with members who are discharged from the hospital with Infusion Therapy needs. We continue to have issues where members are discharged home and need infusion therapy and there is a lack infusion therapy providers in our geographic service area. Originally, our solution to this issue was the addition of an Infusion provider from the Tucson area, however, we have experienced many issues with the provider's billing practices and Medicare billing limitations. This year we sought out A short term resolution to this issue is the coordination of efforts with a pharmacy provider who can deliver the medications to the member's home and authorize the nursing services through a contracted home health agency, or CHS may coordinate services through a skilled nursing facility for the duration of the IV therapy. In addition, if not medically contra-indicated, CHS also authorizes outpatient infusion therapy services, however, at times this is not a practical solution and depends on the frequency of treatment for the member. The long term goal is to secure a contract with an Infusion service agency who can meet our members' needs with the capability of billing within the scope of applicable regulations.

Update 2011-CHS has received a Letter of Intent from Coram Specialty Infusion. This organization, part of the Apria Network, has expressed an interest in working with CHS to expanding infusion services to our GSA.

6. **Outcome measures/evaluation of interventions**

To meet covered service requirements, minimum network standards and to anticipate growth, CHS conducts initial needs assessments for each county in the geographic service area. CHS also gathers Information through:

Provider monitoring (Contracts and Medical & Utilization Management Review) helps identify a provider's ability or inability to provide timely services, or ability to meet the members' needs based on acuity and special needs. Providers are queried about new providers in the area that may be an asset to our network.
Annual M/UM Member, Provider and Behavioral Health Surveys.

Provider census information, for example bed counts in nursing facilities.
Utilization reports and statistics, for example quarterly reviews of HCBS service utilization.
Provider-specific surveys gather information such as: language capabilities of staff or telephonic surveys assess appointment processes and availability of providers. In addition, providers are surveyed to determine if members arrive timely to their appointments and if they are picked up on time. This data helps CHS identify if transport providers are meeting the needs of our members.
Initial & Re-Assessments-CM's use this tool to evaluate a member's needs and develop a care plan. If a member needs a particular service, provider that is not part of the network, this is communicated to the Provider Relations Department for resolution. Resolution would include a letter of agreement or a long-term full status contract. These assessments also help CHS identify the member's satisfaction level with the CHS network.
PAS-The member's PAS may be used as a tool to identify a network gap. For example, if a member rolls onto the program with a non-network provider. We may attempt to expand our network to include this provider depending on the provider (the provider may have already declined to contract or may be out of area).
Case managers are an invaluable tool used to monitor the efficacy of the network. From the onset of a case they communicate with the Provider Relations depart in their efforts to coordinate services. This communication occurs on a daily basis. Sometime they know a provider is leaving before we even have notice or they can express concerns if a member's needs are not being met through the existing network. They also assess timeliness of behavioral health appointments and may identify providers if they are unable to schedule timely appointments.
Prior Authorization Dept- identifies needs for providers particularly specialists with whom CHS may contract for services with or use as non-contracted providers if there is not sufficient need within the population for the specialty. The office also identifies possible trends for delays in receiving appointments.
Member Grievances (expressions of dissatisfaction) and Provider Complaints-Issues and Quality of Care Concerns are two other tools used to identify problems with the existing Network and the possible need to expand service in a particular area.
Quality Circle-this is a fairly new mechanism employed by CHS to allow continuous information between CHS divisions. These circles are lead by a Case Manager and topics range from billing issues, to network concerns and ideas on how to improve departmental processes.
Inter-rater Reliability Work Group-This is a new work group that meets monthly (or more frequently if necessary) whose purpose emerged from an issue identified with a particular category of service. CHS identified a 38% increase in authorized attendant care hours without any material changes to member demographics. From this, CHS launched an extensive research study on attendant care services and identified many issues from fraudulent billing practices to an over authorization of services by CHS case managers. CHS learned many lessons from this study and some actions taken included focused meetings with providers to educate them on proper billing practices, implementation of a sanction policy, focused claims review process to prevent overpayments and fraud and member education on proper documentation practices. The work group is currently in the process of analyzing transportation and durable medical equipment and supply services to identify any potential areas for improvement, to ensure that member's needs are being met while maintaining fiscal responsibility.
Inter-Departmental Cooperation (policy) This is a new policy/process implemented by the Director used to promote coordination and communication across disciplines and sections within the department. The purpose of the policy is to improve on-going communications among the sections of the department with particular emphasis on ensuring coordinated approaches with medical management and quality management.

Network Task Force

The CHS Network Task Force monitors and analyzes the provider network to ensure compliance with Cochise Health Systems quality standards, compliance with ALTCS Minimum Service Requirements, recommends strategies to strengthen the provider network and reviews incoming applications/credentials from

providers who wish to join the network. Annually, the Task Force reviews utilization of services and projects the anticipated utilization of services based on characteristics of population and its health care needs. The bi-monthly Leadership Team meetings serve as a forum for supervisors to discuss Network issues for presentation to the Medical Director, as needed.

The Task Force is chaired by the CHS Director and consists of CHS Management Team: Medical Utilization Manager, Case Management Supervisor, Financial Services Manager and the Member and Provider Relations Supervisor. Representatives are responsible for presenting information based on their position with CHS. For example, the Medical/Utilization Manager presents provider quality concerns for possible corrective action based on contractual specifications and member/provider survey analysis. The Member and Provider Relations Supervisor presents information regarding network management that includes: the ALTCS service site requirement, the status of the current contracted network, and the periodic results of the call tracking system to ensure that provider call, inquiries, complaints and/or questions are responded to timely and appropriately resolved and to analyze for any potential trends/issues within network. The Case Management Supervisor presents information regarding their day-to-day experiences, information regarding member-provider relations, and delivery of care. This would include (but is not limited to) member satisfaction with a particular provider, providers ability to coordinate services with other providers or suggestions on new specialists or other providers for the network.

Forum for Evaluation - Ongoing Reviews:

The specific forums used by the Task Force to review input and evaluate the network capacity include:

CHS quarterly staff meetings
CHS leadership meetings-bi monthly.
Quality circles-These meetings are held monthly. Staff are divided into 5 groups.
M/UM Process Improvement Committee quarterly meetings
Provider/Member Council
Provider Orientation or training meetings (onset of contract and as needed or requested)
Inter-rater reliability work group
Inter-departmental policy/process
Provider Call Tracking

7. Ongoing activities for network development based on identified gaps and future needs projection.

New Development Highlights:

The provider recruitment process for CYE 2009-2010 expanded the CHS network in a multitude of areas. Specifics additions by service type:

Assisted Living—Rainbow Ridge in Sierra Vista, Esther's Adult Care in Douglas and J & B Assisted Living Home were added to the network. Valley Vista Adult Foster care was added to the network last year and this year has expanded services by added more beds to their facility.

HCBS- CHS provides a full range of HCB services from skilled nursing to attendant care, personal care, housekeeping and home delivered meals. The HCB network currently consists of 18 providers within the GSA. This includes Home Health and Paraprofessional services. Last year, Sunlife Home Care expressed their goal of becoming a Medicare certified Home Health Agency and this year has achieved this but services on currently on hold until the provider gives notice to CHS that they are ready to resume services. CHS added Bayada Nursing, this is a home health agency located in Tucson. They will initiate services once they expand their licensure into Cochise County. Last year we reported that

Catholic Community was in the process of transitioning ownership to Legacy Home Health. This finally took place in April of this year.

Scottsdale Village is a new Skilled Nursing Facility in the Maricopa County area that was added to the network. As stated previously this was initially added to accommodate the needs of one member but has expanded into a formal contract. This is especially noteworthy as the facility specializes in behavioral health services.

The Primary Care and Specialist network was our primary focus of network development as eight four Physicians and allied health professionals were credentialed this past year. New PCPs were added in a variety of locations and as always we are still working on adding a few more. CHS added providers from a variety of different disciplines to offer members a flexible and diverse network.

New specialists range from cardiology, dermatology, endocrinology, gastroenterology, neurology and specialties such as plastic surgery. CHS is in the process of adding AFCA Imaging LLC to the network. This provider will offer performing imaging services, ultrasound and dexa (no MRI or CT) and will be a Medicare certified entity, (IDTF=independent testing facility), the films will be read by a radiologists. Southwest PET Institute and Alliance Healthcare Services have also been added to the network.

A Psychiatric Nurse Practitioner has expanded services to the Tucson area specifically services for Skilled Nursing Facilities in collaboration with a Psychiatrist who is also part of our network.

DME services continue to be a challenge and therefore CHS released an RFP in the hopes of securing a contract with additional providers to supplement the existing network. Millennium Medical out of Safford Arizona was added to the network and will be able offer services in the Graham and Greenlee areas of the GSA as well as some parts of Cochise County, depending on the type of service/product. In addition, United Seating and Mobility was recently added to the network primarily for custom DME services.

These efforts ensure quality and continuity of care while offering choice to our members. Given the rural nature of our GSA the best design we can employ for our network is to contract with all available providers and extend the network into Pima and sometimes Maricopa County to meet the needs of our diverse population. These are just example of our efforts this past year; a full copy of the network is attached to this report for your review.

Future Needs Based on Membership Growth

Annual Review of Membership Growth: On an annual basis, at budget time, the CHS Leadership Team reviews projected population growth, specific trends in service delivery, and the effectiveness of provider recruitment efforts during the past year. In October 2009 our membership was at 924, in March 2010 the membership decreased to 908 and by September 30 2010 the membership has further decreased to 884. Overall, there was no membership growth this contract year as evident by the comparison of 941 in 2008 to 949 in 2009 and 884 in September 2010. In fact our membership decreased over the contract year.

Measurement: CHS uses the information gathered through; provider monitoring, annual surveys, provider census information, case managers, and member grievances and provider complaints-issues process, quality of care concerns, M/UM quarterly statistics/annual reports, CHS Leadership Team Meetings, Quality Circles and the Inter-rater Reliability Work Group as a means to measure the effectiveness of our network, to determine future network needs and to determine the effectiveness of actions taken to address any network issues. Measurement includes the capacity for meeting the minimum network standards or specific growth trends in specialty populations. Once information is gathered and evaluated from all potential sources, and if an area of deficiency or needed expansion is noted, the CHS Leadership Team determines the needed development or addition for specific providers. The team then makes recommendations to the Chief Operating Officer who prioritizes the bidding process and contracting process.

Recruitment Determination and Action: Requests for Proposals are publicly advertised competitive bids that provide an open forum for all interested providers. Proposals are considered based on Member needs, rates offered, minimum network requirements and recommendations of the Credentialing Committee. It may be determined that a focused recruitment and contracting effort is necessary to accommodate unique population needs such as members with rare diagnoses, or young members requiring behavioral health services. The Contracts section may survey other program contractors, use existing networks, and use local directories of health care providers to identify potential providers when initiating a bid process. Some strategies used to expand the network may include increases in rates to promote stability within the healthcare community, or working with new companies to explain our program needs. Currently, four PCP contracts are reimbursed at 120% of the AHCCCS FFS schedule (with one pending) and eight specialist contracts with varying percentages.

Alternatives to Recruitment: At times, services may be substituted when providers are not available in a service area. For instance, CHS may use counselors and additional personal care or attendant services in areas where hospice is not available and we may use in-home respite to substitute for adult day health. Multiple providers or every provider available in an area or service category are often contracted to ensure sufficient network capacity in these rural areas.

Given the inherent challenges of a rural area, CHS takes actions to further strengthen the network and gives opportunity of choice by entering into agreements with specialists in Pima and Maricopa Counties such as Assisted Living Home for behavioral management, dentists and rare disorder specialists.

8. Coordination between internal departments:

One of the most effect means of coordination between internal departments are the Quality Circles CHS initiated in 2008. CHS has at least five separate quality circles comprised of employees from each section/department of CHS-Finance/Claims, Case Management, Provider Relations, and Medical/Utilization Management. Initially, the focus was member care but now has evolved to workflow issues between departments, we have found ways to improve different processes, discovered recurring billing problems for providers and issues with encounter and how we all interrelate. There is one main Quality Circle Log maintained by the Director that is created from the minutes of each circle meeting. From here (whenever necessary) the management/leadership team reviews and identifies any possible trends or issues.

CHS also has an Inter-rater Reliability Work Group whose purpose is much the same as the quality circle in that we strive to improve and streamline our business operations, however, the IRR workgroup focuses on specific problems or trends identified and implements strategies for improvement. The team may review the high cost utilization report or an analysis of financials to determine what areas may need review and improvement. This year the focus continued to be the review of attendant care services with the goal of extending to the analysis of nursing care. Last year's analysis/study (of attendant care services) served to improve our focus on prepayment claims review to ensure that services are appropriately delivered and reimbursed. CHS has implemented the sanction policy into contracts and has predominately found the trend to continue in the area of home and community based services however we have observed an improvement for some providers. From this group CHS began focus groups whose purpose was to improve the process for DME authorizations and another team for HCB service authorizations. The DME focus group was temporary and disbursed once new strategies and workflows/protocols were implemented, however, the HCBS team is more permanent. The intent of this group (operated by case management) is to overview the authorization of services to ensure that the authorization of services are consistent among case managers and to ensure that members needs are met particularly (but not exclusively) when providers request an increase in service hours. This group serves as a review board for case management where a case manager may present a case she/he may need assistance on. Overall, the mission of the IRR workgroup is to review covered services, identify any potential areas for improvement, to ensure that member's needs are being met while maintaining fiscal responsibility.

Other mechanisms include quarterly staff meetings, bi-monthly Leadership Team meetings, and M/UM Process Improvement Committee meetings. In addition, results from the annual survey spur coordination between

departments if particular areas of concern are noted, deficiencies are identified depending on the nature of comments received from members and providers.

Inter-Departmental Cooperation (CHS006 Policy) this policy/process implemented by the Director is used to promote coordination, collaboration and communication across disciplines and sections within the CHS. The purpose of the policy is to improve on-going communications among the sections of the department with particular emphasis on ensuring coordinated approaches with medical management and quality management.

9. Coordination with outside organizations; (ALTCS Contractors should address member and provider council activities)

Member/Provider Council:

The Member Provider Council is a collaborative effort of CHS, Network Providers, elder advocates/ombudsmen, CHS Members, and their families or significant others whose goal is to enhance the service delivery system in Cochise, Graham and Greenlee Counties. The Medical and Utilization Management Section is responsible for developing the Plan and coordinating the meetings for the Member/Provider Council. CHS Leadership team members participate along with members and providers as part of the panel and provide input on CHS policy, programs, covered services, additions to the Provider Network, and the delivery of services. The meetings are also used as an opportunity to obtain information on the status of network (from both the provider and member's perspective), to receive feedback on any possible gaps or limitations and to obtain suggestions for new providers or services that could be added to the Network. The Member-Provider Council met each quarter this year and the locations rotated within the GSA to give different members and providers the opportunity to participate. Topics included Utilization of services (Pharmacy, Hospital, HCBC etc), Network Status, Case Management updates such as SDAC program, and grievance and appeal updates. Membership attendance varied each meeting but always included members and providers. Meeting minutes are available upon request.

Outside Organizations and Community Involvement:
CHS is active in community and state-wide organizations to encourage improved care coordination and services in the counties in which it operates.

The Director oversees the Area Agency on Aging Case Management Program, to include a caregiver support program that provides educational and referral services for the caregivers. CHS case managers refer family caregivers to this program. For evidence of this participation please visit the following link
http://cochise.az.gov/cochise_aging_social_services.aspx?id=448&ekmensel=c57efa7b_26_0_448_14

The Director also a board member for Chiricahua Community Health Clinic, a federally funded rural health clinic who operates three clinics in Cochise County and offers a wide variety of services from primary care, ancillary services. This board meets at least monthly. For evidence of this participation please visit the following link:
http://www.cchci.org/directors.htm

The Director is part of the Cochise Network Association. One of the work groups is ARCHIE or the Arizona Rural Community Health Information Exchange. Their mission is to provide ready access to complete and correct healthcare thru secure health information exchange in SEAZ. ARCHIE hopes to connect as many healthcare providers in Cochise County with other HEIs in the State. They are working closely with AHCCCS Health e-Initiative.

Relay for Life (American Cancer Society). In 2010 the relay raised $28,000.00 and donated over 2500.00 back into the community. Through fund raisers, back sales, community donations and sponsorship from local business. The main committee meets once a month. Many CHS employees are involved in this event each year.

Another employee attends quarterly meetings as a community partner in the Copper Queen Professional Advisory Committee. This agency oversees the Copper Queen Home Health Agency. Over the past six months the employee attended three meetings due to a state review of their agency and many discrepancies that were found. We discussed the inspection findings, identified problem areas and developed their Plan of Correction. The agency is working hard to improve their processes and have made many positive changes. As a member, they ask for input and suggestions on their interventions.

Another employee participates in a Christmas in Naco function by the Rotary Club-- Every Christmas Day: participants distribute gather donated clothes, get donation of money to buy large quantities of food and new blankets. This committee meets once a week and also emails information such as meeting dates to gather the donated items (clothes, food and blankets) and prepares them for Christmas morning. Police from both sides of the line are there to assistance with this endeavor.

Another employee is a board member for Southeastern Arizona Medical Center and also participate the SAMC Quality Improvement and Credentialing Committee and is a member of the Domestic Violence Awareness Committee which is part of CCS DV outreach efforts.

CHS shall participate this next year in the Cochise Elder Abuse Prevention Partnership. This group meets each month to discuss elder abuse prevention from different perspectives of each member. Membership includes representatives from Bisbee Senior Center, Cochise County Sheriff's Department, Southern Arizona Legal Aid and the Southeastern Arizona Governments Organization (SEAGO).

The Case Management Supervisor participated on the Emergency preparedness task force that is part of the Cochise County Health Department.

10. **A description of network design by GSA for the general population, including details regarding special populations. [Acute contractors should understand these populations to include the developmentally delayed (Arizona Early Intervention Program (AzEIP)), the homeless and those in border communities; among others. ALTCS Program Contractors should understand these populations to include behavioral health; young adults and children; among others.] The description should cover:**

The design of the CHS network has evolved from the geography of this rural service area. That means CHS seeks contracts with all providers in each main city in Cochise County, in Safford for Graham county and Morenci/Clifton in Greenlee County because each area of the GSA is considered a medically underserved area.

In Cochise County, most all PCPs are contracted with CHS with the exception of those who have declined to contract. Some primary care providers in Sierra Vista and one in Douglas have declined to contract with CHS, otherwise, all other PCPs in Cochise County are contract with CHS.

In Graham County, CHS is contracted with all but one clinic of primary care providers and in Greenlee, there is very little in the way of the network because it is such a remote area of Arizona. As previously stated, CHS is attempted to secure a contract with Gila Health Resources for PCP and other ancillary services.

The Hospitals in Cochise County and in Safford are contracted to provide both inpatient and outpatient services to include laboratory, radiology, medical imaging and therapy services. The network includes SNF in each available area- Douglas, Sierra Vista, Benson, Willcox and Safford and additional SNF in Pima County. Our SNFs in each area are also contracted for therapy services for both residents and outpatient services.

Sierra Vista is a small medical hub where many medical services are available, more so than any other area of Cochise County. In Sierra Vista, many specialists offer clinics or maintain satellite locations, there are urgent care clinics available, ambulatory surgery centers and sleep labs. Rather than transporting members to Tucson, we first differ to our

own network of providers most of whom are located in Sierra Vista or other areas of Cochise County where services may be available.

Safford is also a medical hub run through Mt. Graham Regional Medical Center. In Safford, members have the choice of some specialists in the field of allergy, cardiology, nephrology, oncology, podiatry and more.

CHS also has a network of providers contracted in Pima County who offer services in each of the counties on a monthly basis. Appointments are setup up during a clinic within the GSA or in Pima if medically contraindicated.

The network of Home and Community Based Services is comprised of all the available providers in the area. As these providers emerge, CHS opens an RFP to build the network and offer choice to our members.

The ALF network offers a placement in each main city of Cochise County, with multiple options in Sierra Vista and a new home open in the Benson area. There are no ALF in Greenlee County, however, there are four located in the Safford area of Graham County.

The Behavioral Health network includes all the SEABHS sites in each main area of Cochise County, Safford and Morenci/Clifton. Benson is the SEABHS main site where they offer more than just outpatient services such as the PHF and other Alternative Residential Facilities run by SEABHS. In addition, Bisbee, Sierra Vista and Safford offer other independent BH services. With the award of the new Regional Behavioral Authority contract, CHS hopes to gain new providers and is already in contact with Cenpatico to establish contacts for the new providers with the goal of new agreements and an expansion of the network. **Update 2011**-CHS has secured new agreements with two new outpatient providers in the Cochise County area. This is a work in progress as the provider finalizes licensure through ADHS and AHCCCS registrations for the various locations in the GSA.

There are no skilled nursing facilities in Cochise, Graham or Greenlee Counties that specialize in behavioral health. Therefore, CHS contracts with many of the facilities in Pima County to prevent any gaps in service. CHS is contracted with eight facilities in the Tucson area bringing the number of Skilled Nursing Facilities in the Network to sixteen (this number includes two swing bed facilities one in Benson and one in Willcox), seven of which have Behavioral Health Management Units. In addition, this year CHS added a contract with Scottsdale Village Square in Maricopa County who also provider behavioral management services and have option (whenever availability allows) for the negotiation of Letters of Agreements with facilities such as Ridgecrest or Desert Haven in Maricopa when deemed necessary. This ensures member placement if local facilities are temporarily full, and prevents any gaps in service. This also serves to provide options particularly for members with highly specialized needs, behavioral problems, or rare diagnoses. These additions will also ensure continuity of care should any of the contracted facilities in the GSA abruptly discontinue services. For short-term resolutions (specifically for members on a waiting list or members with specialized needs) CHS will continue to use Letter of Agreements for facilities that do not have existing contracts. These agreements will cover members who roll onto the program until they can be placed in a Network facility and in cases where the member may have unique Behavioral Health needs. The approach toward long-term resolution will be to contract with behavioral health providers within our GSA as they become available and to assist existing facilities with expansion projects for behavioral health as they emerge. Last year, Quiburi Mission Skilled Nursing Facility was in the process of expanding services to include a behavioral management and wander dementia unit. The facility "broke ground" in 2009 for the expansion project and CHS is now contracted Quiburi for this service. The facility did not expand for behavioral services but did expand for a wander dementia/Alzheimer's Unit where some members are currently placed.

Our network is structured to include Pima and Maricopa County SNF's to ensure member placement if facilities within our GSA are temporarily full, and prevents any gaps in service. This also serves to provide options particularly for members with highly specialized needs, behavioral problems, or rare diagnoses. These additions will also ensure continuity of care should any of the contracted facilities in the GSA abruptly discontinue services.

Currently CHS has contracts with Easter Seals Blake Foundation and Intermountain Centers for Habilitation and Letters of Agreement with Graham County ARC and Douglas ARC for habilitation services. In Cochise County there are ARC agencies offering services in Sierra Vista and Bisbee that we will contract with if needed. Our network of providers offer a range of services for special populations including habilitation, group home service, supportive employment programs and outpatient services in conjunction with a therapeutic residential setting. In addition, CHS is contracted with ABRio Family Support and Services (a HCB provider) to include habilitation services. Services will be available to members in Cochise and Graham Counties. The short and long-term resolution has been to maintain a list of providers available in each area of Cochise, Graham and Greenlee Counties and negotiate the provision of services, with a Letter of Agreement, as member needs arise.

Intermountain and the Blake Foundation provide a wide range of services for our members, particularly our young adult population with behavioral needs. The Easter Seals/Blake Foundation also operates community living service homes for individuals with special needs in Sierra Vista and Tucson. There are two Sierra Vista locations for men only and three members are receiving services. Intermountain is also contracted to provide BH Outpatient Services, Level II Behavioral Health Residential Services and Behavioral Health Therapeutic Homes. Currently we have four members receiving services with Intermountain.

Community Provider of Enrichment Services is a provider who offers a full range of home and community based services that include transportation and habilitation. Currently we have a member receiving all inclusive residential habilitation services. CPES is now also contracted to provide counseling services in the Tucson area, this especially beneficial for our membership located in either ALF or SNF in Pima County.

Services through Compass Health for the MICA Program (Mentally Ill Chemically Addicted) for Vida Serena, a Level II Residential Treatment Program are available through letters of agreement. This program provides comprehensive addiction and mental illness treatment for adults who require a structured environment with 24-hour monitoring. The program's clinical focus is on both mental illness and addiction as clients learn to understand, accept, and cope with the problems. The program includes a 30-day treatment program for substance abuse followed by a 30-day re-entry transitional program that allows the members completing residential treatment the opportunity to solidify their recovery program while assuming more financial responsibility and enter the job market. The member will remain sober, in a 12-step-based community with counseling available. The goal of their program is to prepare the member to re-enter the community with a firm foundation for continued sobriety

(i & ii) <u>How members access services and relationships among the various levels:</u>

On an annual basis, CHS prepares a member handbook in English and Spanish that welcomes members to the Cochise Health System. The handbook explains in simple terms how to access services. It explains in detail that a Case Manager is assigned to the member and is the member's one-on-one contact for assistance with the program. It explains the role of the Case Manager, the service plan that is developed for the member, services available, such as how to choose a doctor, how to change to another doctor, how to schedule an appointment, emergency services, pharmacy services, etc. In addition to mailing a copy to each of our members, the member handbook is available on our website @ http://cochise.az.gov/uploadedFiles/Aging_and_Social_Services/ENG_MemberHandbook.pdf. This is also available in Spanish. Member communications such as the handbook and newsletters are in accordance with state and federal regulations and AHCCCS policy. Please refer to the CHS Cultural Competency Plan for additional information.

The member newsletter is another resource for members and provides information on how to access services. This newsletter is published twice a year and includes educational information, reminders on flu shots and other prevention measures. The most recent newsletter included information an article from our Medical Director on Immunizations/Vaccines. The publication also included information on the Adult Benefit Changes, Cultural Competency and Medicare D Information. The spring newsletter included an article on Diabetic Care, HIV/AIDS and pregnancy testing and fraud and abuse. This newsletter is mailed out bi-annually to members, is available in Spanish and is also available on the Cochise County website.

The case manager meets with the member and/or family within the first ten days the member comes on to the Program. A list of PCP providers is given to the member who makes a choice of which PCP he/she wishes to be assigned. An assessment is made to decide what long-term care services are required to meet the member's medical needs. The Case Manager develops a service plan, explains what services are available based on the needs of the member and arranges for services such as Skilled Nursing Home, Assisted Living, or Home and Community Based Services (home delivered meals or homemaker services). For those members receiving HCB services, a Contingency Plan is developed at the time of initial assessment to prevent any gaps in HCBS services (refer to the most recent November 2010 semi-annual Ball vs Betlach reports for further details on Contingency Plans).

Members who live at home are able to schedule their own appointments with their PCP and may contact their Case Manager if they require assistance. If they reside in a Nursing Home, the PCP provides regular visits at the facility. The Nursing Home staff can contact the PCP to arrange a visit if required outside the normally scheduled visit. The PCP is responsible for all health care and will make referrals for specialty services when needed. If a member resides in an Assisted Living Facility (ALF), the ALF will schedule appoints on behalf of the member.
The CHS provider directory on the website is another method both members and providers may access the system. This network is now available as a searchable directory. Users may look up a provider by name, address, zip code, specialty, and provider type (name not the number—for example Hospital). The network is revised and mailed out quarterly to providers. Members receive a copy of the network via the handbook revisions that are mailed out each year. This network includes (is not limited to); PCPs, Specialists, Hospitals, Pharmacies, SNF and Alternative Residential providers.

Access of members to Specialty Services

The Case Manager works closely with the member, the PCP, the Prior Authorization Section of Medical Management and the Contracts Section when the need for Specialty Services is identified. The member's PCP will make referrals for specialist visits/services. The only exceptions are well women services and dental services for children. The member may choose these services from any CHS contracted specialist without prior authorization. The Case Manager works closely with the Prior Authorization Department to ensure the timely referral for specialty services. If the service that is required is outside of our Network, the Prior Authorization Section notifies the Contracts Section who in turn arranges for the service to be provided through a Letter Agreement with the provider for temporary service or until a formal contract can be arranged.

Selection of specialists practicing outside the geographic service area is also contingent upon certain service requirements, such as minimum network standards, medical necessity for members and the location of service provision. CHS emphasizes contracting not only with in-county specialists, but also out of county specialists who maintain service sites in any city within the geographic service area. Member appointments are scheduled whenever possible during the in-county office hours unless medically contra-indicated.

iv. (ALTCS Only) The description should include a list of these providers along with a description of services provided by the program and projected utilization. Please refer to the CHS network for a complete listing of contracted behavioral health providers available to all members including young adults and children. Briefly, CHS contracts with Intermountain, Easter Seals/Blake Foundation for Outpatient BH Services, Habilitation Services and Behavioral Health Therapeutic Home Care Services, CPES for both Outpatient Clinic Services and Behavioral Management Services, Psychiatry Services: Dr. William Sullivan and Dr James Reed and other psychiatrists and allied health professionals through Southeast Arizona Behavioral Health Services (SEABHS),- for members needs within the GSA. Psychiatric Nurse Practitioner Services: Kathleen Oldfather PNP and Chad Rubin PNP-Cochise and Pima Counties, and Outpatient Clinic Services-SEABHS Cochise Graham and Greenlee Counties. CHS has also recently credentialed a psychiatrist in the Maricopa county area for members placed in Skilled Nursing Facilities in the area. Please refer to our network for all other services available to members. In addition, with the award of the new Regional Behavioral Authority contract, CHS hopes to gain new providers and is already in contact with Cenpatico to establish contacts for the new providers with the goal of new agreements and an expansion of the behavioral health network.

This network is more than adequate to meet the needs of our members and accommodate even a 5% growth rate. Utilization of these services has increased slightly but the network also increases and adequately absorbs the demand.

11. A description of the adequacy of the geographic access to tertiary hospital services for the Contractor's membership.

CHS is contracted with all five local hospitals in Cochise County, and the one/only hospital in Graham County. We are also contracted with three tertiary care facilities in Tucson – TMC, St. Mary's and St. Joseph's. The local hospitals are not tertiary care facilities and any members requiring tertiary care are transported (based on their acuity) via contracted ground ambulance or via air to one of our three tertiary care facilities in Tucson. In cases where these facilities are on divert, the member is transported to the closest hospital that has an available bed.

There is no local hospital in Greenlee County and patients are referred to Mt. Graham Regional Medical Center in Safford. If one of the members assigned to these physicians is admitted to Mt. Graham, he/she is assigned to one of the local community physicians who have privileges at the hospital and who assumes responsibility for their care while the member is in the hospital. The assigned physician then coordinates any follow-up care with the member's Primary Care Physician.

(12 & 13 Acute only)

14. The methodology (ies) the Contractor uses to collect and analyze member, provider and staff feedback about the network designs and performance. When specific issues are identified, the protocols for handling them.

The following methodologies are tools used to obtain feedback about the providers and serve also as a means to obtain feedback from the providers about the network design and implementation.

Provider monitoring (Contracts and Medical & Utilization Management Review) helps identify a provider's ability or inability to provide timely services, or ability to meet the members' needs based on acuity and special needs. Providers are queried about new providers in the area that may be an asset to our network. Utilization reports, for example quarterly reviews of HCBS service utilization.
Provider-specific surveys gather information such as: language capabilities of staff or telephonic surveys assess appointment processes and availability of providers. In addition, providers are surveyed to determine if members arrive timely to their appointments and if they are picked up on time. This data helps CHS identify if transport providers are meeting the needs of our members.
Initial & Re-Assessments-Case Management uses these tools to evaluate a member's needs and develop a care plan. If a member needs a particular service, provider that is not part of the network, this is communicated to the Provider Relations Department for resolution. Resolution would include a letter of agreement or a long term full status contract. These assessments also help CHS identify the member's satisfaction level with the CHS network.
Case managers are an invaluable tool used to monitor the efficacy of the network. From the onset of a case they communicate with the Provider Relations depart in their efforts to coordinate services. This communication occurs on a daily basis. Sometime they know a provider is leaving before we even have notice or they can express concerns if a member's needs are not being met through the existing network. They also assess timeliness of behavioral health appointments and may identify providers if they are unable to schedule timely appointments.
Prior Authorization office identifies needs for providers particularly specialists with whom CHS may contract for services with or use as non-contracted providers if there is not sufficient need within the population for the specialty. The office also identifies possible trends for delays in receiving appointments.
Grievance System (expressions of dissatisfaction) and Provider Complaints-Issues and Quality of Care Concerns are two other tools used to identify problems with the existing Network and the possible need to expand service in a particular area.

Quality Circle-One of the most effect means of coordination between internal departments are the Quality Circles CHS initiated in 2008. CHS has at least five separate quality circles comprised of employees from each section/department of

CHS-Finance/Claims, Case Management, Provider Relations, and Medical/Utilization Management. Initially, the focus was member care but now has evolved to workflow issues between departments, we have found ways to improve different processes, discovered recurring billing problems for providers and issues with encounter and how we all interrelate. There is one main Quality Circle Log maintained by the Director that is created from the minutes of each circle meeting. From here (whenever necessary) the management/leadership team reviews and identifies any possible trends or issues.

CHS also has an Inter-rater Reliability Work Group whose purpose is much the same as the quality circle in that we strive to improve and streamline our business operations, however, the IRR workgroup focuses on specific problems or trends identified and implements strategies for improvement. The team may review the high cost utilization report or an analysis of financials to determine what areas may need review and improvement. This year the focus continued to be the review of attendant care services with the goal of extending to the analysis of nursing care. Last year's analysis/study (of attendant care services) served to improve our focus on prepayment claims review to ensure that services are appropriately delivered and reimbursed. CHS has implemented the sanction policy into contracts and has predominately found the trend to continue in the area of home and community based services however we have observed an improvement for some providers. From this group CHS began focus groups whose purpose was to improve the process for DME authorizations and another team for HCB service authorizations. The DME focus group was temporary and disbursed once new strategies and workflows/protocols were implemented, however, the HCBS team is more permanent. The intent of this group (operated by case management) is to overview the authorization of services to ensure that the authorization of services are consistent among case managers and to ensure that members needs are met particularly (but not exclusively) when providers request an increase in service hours. This group serves as a review board for case management where a case manager may present a case she/he may need assistance on. Overall, the mission of the IRR workgroup is to review covered services, identify any potential areas for improvement, to ensure that member's needs are being met while maintaining fiscal responsibility.

Other Mechanisms include (but are not limited to)-Annual M/UM Member, Provider and Behavioral Health Surveys, quarterly staff meetings, bi-monthly Leadership Team meetings, and M/UM Process Improvement Committee meetings. In addition, results from the annual survey spur coordination between departments if particular areas of concern are noted, deficiencies are identified depending on the nature of comments received from members and providers.

Inter-Departmental Cooperation (CHS006 Policy) this policy/process implemented by the Director is used to promote coordination, collaboration and communication across disciplines and sections within the CHS. The purpose of the policy is to improve on-going communications among the sections of the department with particular emphasis on ensuring coordinated approaches with medical management and quality management.

Physician Accessibility

In conjunction with on-site facility reviews, CHS also conducts annual surveys of sub-contracted primary care and certain specialist providers to determine physician accessibility, compliance with ALTCS appointment standards and contractual requirements, and to ensure that timely and appropriate medical services and advice are available to CHS members, this includes out of network providers that are used on a case by case basis if a prior authorization is completed for an out of network physician (UM003), that information is relayed to the Provider Relations Department for inclusion on the annual physician accessibility survey. This tool is also useful in identifying potential Contractors and also for credentialing purposes.

The survey is conducted in a random fashion and consists of particular criterion determined by the Quality/Utilization Improvement Committee. Criterion include: How many times the telephone rings before the call is answered, how long the caller is on hold, whether or not advice was given regarding an emergency situation and whether or not instructions

were offered in more than one language. Survey results are recorded and maintained in the provider's permanent file. Those providers failing to meet particular requirements are notified and resurveyed in three months to determine corrective action. In addition, information is submitted to Medical/Utilization Management for trending purposes.

Results of provider monitoring and physician surveys are reported to the Quality/Utilization Improvement Committee annually as a means of verifying stability within the network. Any deficiencies or gaps in the network are reported to the Provider Relations Supervisor for immediate action.

Provider Quality of Care

CHS M/UM Staff monitor various subcontractors on a annual basis (in accordance with AHCCCS policy), and maintain summary data regarding the results of the visits by contract year, the information is then presented as part of the annual QM/UM Plans.

CHS M/UM Staff maintain a member/provider informal complaint log to identify problems with network capacity, individual service provision or trends regarding quality of care.

In accordance with policy, when any CHS staff member receives a complaint and resolves the situation, they complete the Member Grievance and Provider Complaint Process and forward it to Medical/Utilization Management section. The M/UM staff determine the efficacy of the resolution then evaluate the log. If the resolution is agreeable to the member, the issue is considered closed and filed with Medical/Utilization Management. If the proposed resolution is not accepted by the member, and within 10 days of the complaint, the member is advised of their right to submit a grievance orally or in writing, and is forwarded to the Claims Dispute and Member Appeals Manager. If the issue is deemed a Quality of Care Concern, the issue is processed according to the Quality of Care Concern policy. Any Quality of Care Concerns or trends identified as contractual non-compliance are forwarded to the Contracts Section for action in accordance with contract provisions. In addition, the Quality Utilization Management and Improvement Committee reviews Quality of Care Concerns or trends on a quarterly basis. Recommendations may be made by the QIC regarding possible action by CHS.

Providers who do not correct the problem may be sanctioned or suspended from providing services until there is satisfactory resolution, such as hiring or training of staff. Ultimately, the contract may be terminated if one quality of care concern is not resolved /corrected. If any contractor is suspected of submitting fraudulent billing, or committing any fraudulent act the provider is immediately reported to AHCCCS Office of Program Integrity.

Annual Provider, Member, and Behavioral Health Surveys are another source of input regarding the Network. These surveys give CHS the opportunity to identify opportunities for quality improvement within all aspects of the organization and implement process improvement as applicable. The results help identify member or provider satisfaction or dissatisfaction with particular providers, lack of providers, deficient appointment standards, and lengthy wait times for the various services. The survey also may identify providers whose best practices are recognized by members.

The surveys not only enable CHS to identify limitations or gaps but they also help CHS recognize areas where providers might require education or training specific to our member population. For example, a long-standing physician in the community might overlook the specific needs of the elderly population in contrast to the mainstream of their panel population.

The survey results are used to assist Contracts Staff in identifying areas of service for new development, amending work statements, or development of new training topics and are one of the criteria used in awarding physician incentive bonuses.

Historically, the CHS Provider Survey has shown a high level of satisfaction with operations and responsiveness. The results of the survey are now available on the CHS Website and there was an average of 95% satisfaction. The survey results also will be included in detail in the QM/UM plans December 15 2010. Results are available at:

http://cochise.az.gov/uploadedFiles/Aging_and_Social_Services/SATISFACTION%20SURVEY%20RESULTS%20CMPLT.pdf

Provider Education and Training

Cochise Health Systems' goal and objective is to create and operate a program that provides high quality care and supports member choice. One facet of this objective is achieved through our close ties with the local healthcare professionals and by employing staff from the community.

Through annual surveys, monitoring visits, and day-to-day contact, CHS staff provides face-to-face interactions and responsiveness to member and provider needs. CHS Contracts staff also keeps abreast of changes or trends that warrant education and/or training for staff members and providers.

Initial visits are used as a training mechanism with new contractors to ensure that providers understand the program and the various rules and regulations that apply to it. The training varies based on the contracted service, but focuses on compliance with service expectations, claim submission requirements, authorization requirements, other contract specifications, contacts with CHS, the Provider Manual and how to use it and the Formulary, if applicable.

Issues raised by a specific provider in a monitoring visit may be addressed with similar providers through in-service or training sessions and used as a mechanism to maintain continuity of provider services and to disseminate information to the Network of Providers. Providers are encouraged to contact the CHS Administrative Office with questions or concerns at any time. During training and in-service sessions, they are made aware of their grievance and hearing rights. This information is also identified in the Provider Manual, their contract, via notices mailed with the remittance advice, and/or sent with claims that have been denied.

Any material changes arising from a provider training and/or in-service are formally amended in all contracts as they apply.

The Member/Provider Council is another way we provide education to our providers. It is a collaborative effort of CHS, Network Providers, elder advocates/ombudsmen, CHS Members, their families and/or significant others whose goal is to enhance the service delivery system in Cochise, Graham and Greenlee Counties. The Medical and Utilization Management Section is responsible for developing the Plan and coordinating the meetings for the Member/Provider Council. The Member and Provider Relations Supervisor participates as a panel member and provides input on CHS policy, programs, covered services, additions to the Provider Network, and the delivery of services. The meetings are also used as an opportunity to obtain information on the current status of network from both the provider and member's perspective, feedback on any possible gaps or limitations and to obtain suggestions for new providers or services that could be added to the Network. The Provider-Member Council meets quarterly. CHS has tried several things in the last year in an effort to increase participation at the meetings. We began rotating the meetings to different locations to allow easier access to meetings and greater participation by members, families and providers. Previously, we had a member who identified interest in participating but was not able to physically come to the meeting because of mobility issues. We arranged to have the member participate telephonically and stopped at the residence to obtain the signature on the confidentiality statement prior to the meeting. CHS had thought to explore this method as a means of increasing participation but the member found it quite difficult to hear the meeting and therefore we will not be pursuing this option. This fall we have stated in the newsletter that members could contact CHS if they needed assistance in attending the meetings. We will continue to rotate the meetings throughout the county and will report next plan whether more members attend as the result of CHS offering assistance for attendance.

The CHS Newsletter and other provider mailings (distributed through Provider Relations, Claims or M/UM) are used as training tools to reiterate changes in rules/requirements from AHCCCS that may also have been relayed in the previous Provider Manual Update, contract amendments, or communication directly from AHCCCS. Newsletters are also used to relay new information that may have arrived after the previous manual update, network changes, results of provider surveys, and information about CHS staff. The Newsletters are a useful mechanism to education Community Providers about Cochise Health Systems and potentially act as a recruitment tool for CHS. The CHS Newsletter is available:

http://cochise.az.gov/cochise_aging_social_services.aspx?id=3924&ekmensel=c580fa7b_150_272_3924_10

Subcontractors also receive a copy of the Cochise Health Systems Provider Manual that is incorporated by reference into the subcontracts and includes specifications as required by AHCCCS. Provider Manuals are distributed once contracts are fully executed and awarded to the provider or upon request before the completion of the contracting process. The Provider Manual is updated quarterly on the CHS Website, and subcontractors are notified of the changes.

Again, communication is encouraged and CHS encourages providers to contact administration at any time, especially as problems arise and not months later. This manner of communication assists CHS in the development of specialized training sessions with our providers by identifying issues that might require clarification or are areas of concern for either provider or member.

CHS also views provider monitoring as a tool to promote cultural awareness. On site reviews are used to identify communication barriers with members and possible means of resolution including the use of other more appropriate providers with more diverse linguistic skills and cultural understanding. Annually, CHS sends providers a guide to culturally competent patient care. This information is also available to all providers on the CHS website @www.co.cochise.az.us/CASS/CHS.htm. In addition, CHS offers a cultural competency in-service once a year to all staff and providers.

CHS hosts annual training for staff and also offers to providers. CHS guest speakers have included Assistant Attorney General, Adult Protective Services representative and CHS M/UM Manager have all offered in-services on fraud and abuse over the last few years. In March 2010, the Fraud/Abuse Guest Speaker was Vicki Haviland, Public Fiduciary. The training was a power point presentation defining the duties and roles of the Public Fiduciary, explained parts of ARS regarding guardianship and the intake process for referrals. This power point is available upon request. In addition to this, CHS staff members participated on the online power point fraud/abuse training offered by AHCCCS. CHS again held specific meetings with some HCB contractors this contract year based on prepayment claims review findings. In some cases providers were sent cure notices (refer to CHS sanction policy ADM022) and CHS received corrective action plans from the providers. CHS was able to verify the suspected fraudulent documentation with inpatient claims and medical records with admission times and in some cases ambulance trip reports with recorded times. All HCB contractors were educated on Arizona state laws regarding Fraud last year. This language is now included in each contract and CHS reports all cases of suspected fraud to the Office of Program Integrity.

There was a variety of training sessions offered to both CHS Staff and Contracted Providers this past contract year. Topics ranged from Cultural Diversity, HIPAA, and behavioral health.

Medical Direction

In accordance with AHCCCS regulation, CHS employs the expertise of a physician appointed as the Medical Director to ensure that all medical decisions are made within the appropriate lines of responsibility and authority.

For contracting purposes, the Medical Director oversees all Medical/Utilization Management issues and concerns related to the Network and providers, reviews contracts policies and procedures, chairs the CHS Peer Review and Credentialing process and the Quality Improvement Committee, and consults with Contracts staff on other contractual issues

The Medical Director assists in network development by identification of potential providers for medically necessary services, contacting physicians or other medical professionals as necessary and making recommendations for network additions or deletions based on Peer Review findings and/or utilization report reviews.

In addition, the Medical Director assists with and/or provides input and oversight into the educational needs of providers, staff and members.

This contract year one new providers is being added to the credentialing/peer review committee. Dr. Stephen Lindstrom, a community physician will participate in the next committee meeting scheduled in January 2011. The committee

currently consists of Dr. Parag Patel, Dr. Christopher Spooner and Dr. Mark Curtis. Dr. Patel is offers services as an outside medical review for CHS on Member Appeal cases and Dr. Mark Curtis, DDS is the CHS Dental Coordinator. Dr. Spooner is a board certified specialist in infectious disease.

15. Listing of non-Medicare Certified Home Health Agencies the Contractor is using. The listing is to be provided on the form distributed by AHCCCS and attached to the Plan. (AMPM Policy 1240) (See Attachment A)

See Attached.

16. The strategies the Program Contractor has for Work Force Development. Program Contractors make up the largest payer group for paraprofessionals in the long term care market and must leverage this to ensure adequate resources in the future. Successful efforts to recruit, retain and maintain a long-term care workforce are necessary to meet the needs of the anticipated growth in the ALTCS membership. The Program Contractor must have as part of their network development plan a component regarding paraprofessional work force development in nursing facilities, alternative residential facilities and in-home (attendant care, personal care and homemaker). Work Force Development is defined as all activities that increase the number of individuals participating in the long-term health care workforce. It includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for the continued training of current caregivers (i.e. Program Contractor supported/sponsored training). Work Force Development also includes efforts to review compensation and benefit incentives, while providing a plan for the expansion of the paraprofessional network at all levels of client care.

As the largest payer group for paraprofessionals in the long-term care market in Cochise County, CHS realizes the potential to positively influence the Work Force for this group to ensure a strong network of providers for the upcoming years.

The most effective way we can promote workforce development is through procurement. CHS is contracted with every available home care provider in Cochise and Graham Counties. These efforts alone support the employment industry for both the employer and employee while providing a board spectrum of agencies available to members.

On a case by case basis, CHS amends an existing agreement or enters into a letter of agreement (LOA) to expand services for members with special health care needs. For example, CHS negotiate a separate LOA for a member who needs split shifts and requires caregivers at different intervals of a day at off peak hours such as 6am or 9pm special times during the day from 6 am to 9pm. CHS may also negotiate LOAs for members whose needs are more complex than the general population of members. Other options include splitting the shifts between agencies to meet the needs of one member. For example we may have AccentCare provide morning services for a member but Sunlife for the evening shift.

CHS provides a full range of HCB services from skilled nursing to attendant care, personal care, housekeeping and home delivered meals. The HCB network currently consists of 18 providers within the GSA. This includes Home Health and Paraprofessional services. Last year, Sunlife Home Care expressed their goal of becoming a Medicare certified Home Health Agency and this year has achieved this but services on currently on hold until the provider gives notice to CHS that they are ready to resume services. The owner selected this location to enable a wider radius of coverage extending into Bisbee and Graham County. This will also increase the workforce in this area as there is currently no home care agency located in Willcox. CHS added Bayada Nursing, this is a home health agency located in Tucson. They will initiate services once they expand their licensure into Cochise County. Last year we reported that Catholic Community was in the process of transitioning ownership to Legacy Home Health. This finally took place in April of this year.

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AccentCare, an existing contractor with CHS, added a service site in the Douglas area of Cochise County. This provider now has three separate locations spread throughout Cochise County to meet the needs of our membership.

Our recruitment efforts also support the assisted living home/alternative residential workforce. CHS added Rainbow Ridge in Sierra Vista, Esther's Adult Care in Douglas and J & B Assisted Living Home were added to the network. Valley Vista Adult Foster care was added to the network last year and this year has expanded services by added more beds to their facility.

Quiburi Mission in Benson expanded services to include a secured wandering dementia/Alzheimer's health unit. This is beneficial to CHS on many levels. In terms of workforce, this addition added more jobs to the area and expand services to members with higher levels of care in Cochise County. At this time, members with higher level health needs must be placed at facilities in Pima County. Having a facility capable of managing higher levels of care is a wonderful asset to our community.

In support of the Direct Care Workforce Initiatives by AHCCCS, CHS has begun to educate providers about the upcoming changes to the training requirements for direct care providers. Throughout the year, CHS has educated the HCB providers through the DCW periodic newsletters providers every few months. In addition some of the network providers are on the DCW committee.

This April CHS participated in the DCW workshop held in Sierra Vista in conjunction with Jutta Ulrich the DCW specialist with AZDES and SEAGO. Jutta Ulrich wrote..." The DCW workshop in Sierra Vista was a huge success: The presenters felt good about it, the participants seemed satisfied - they were a really active, interested group. A big thank you to all of you for helping with the arrangements and getting the word out. We could not have done it without you. Reverend Studer - thank you specifically for the use of your church meeting rooms; it was a perfect set up. Kathleen (SEAGO) and Mary (CHS) - thank you for taking care of all the little details; this must have taken quite a bit of time and effort. We hope that this was a worthwhile event for your region".

This year CHS added a review of the compensation and benefit plans to the monitoring tools used each year. Specifically CHS ask provider to: "Please describe the employee benefits offered by your organization to include salary incentives, paid time off such as vacation or sick time, retirement benefits and other programs offered by your company" From this CHS has a one page report that summarizes the benefits offered by each agency (this is available upon request). Overall each agency offers some form of Employee Benefit that range from paid vacation and sick time to medical insurance including dental and vision. Some offered mileage as a form of benefits and travel time.

The Member/Provider Council Meetings were also used as a forum to discuss Direct Care and Workforce development. A brief overview was provided at one of the council meetings and direct care brochures were distributed to attendees.

In the past CHS has posted the Direct Care pamphlets (by AZDES) at some of the local business such as Chiricahua Community Health in Bisbee and the Bisbee DES office. These pamphlets educate the public on direct care professionals and offer information on how pursue this career choice. CHS intends to initiate this next year.

The Area of Agency on Aging, A Division of Cochise Aging and Social Services also offers Free Caregiver Training on monthly basis. Topics range from Is home care for you, duties of caregivers, preparing the home for your family members care and safety, equipment and supplies, infection control and making the most of everyone's day. Along with free training, the AAA program puts out a monthly newsletter to caregivers in Cochise County for educational purposes and to keep them informed on current events and as an open invitation to the monthly training. There are 80 plus providers registered for the newsletter and trainings.

Family members are a significant component of the current in-home workforce and for the foreseeable future will be critical to expanding this workforce. As such, in an effort to support care-giving families, CHS contracts with home

care providers who employ family members for continuity of care. Four contracted providers offer family care services. Along this continuum, CHS contracted with Accent Care for a variation of the Self-Directed Attendant Care model. The services still fall under the tradition model of attendant care, however, the agency works with the member to hire their own caregiver. Given this critical component to workforce development, CHS will periodically (each quarter) analyze the family attendant care data through utilization reports for the purpose of ensuring that family members are part of this workforce, account for a significant portion of the attendant care workforce and monitor growth patterns to ensure stability within the workforce for the foreseeable future. In addition, these efforts shall service as a mechanism of data validation for our health information system and encounter submissions.

Other forums for workforce development includes: bi-monthly leadership meetings, Quality Circles and monthly HCB provider meetings to discuss possibilities on how to promote workforce development in our GSA as well as discuss the current status of the network and member care issues.

17. Strategies the Contractor will take to provide members with "in-home" HCBS versus placing members in Assisted Living Facilities and Nursing Facilities. A priority should be placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institutional or alternative residential setting.

Our members are scattered between 13,000 square miles in three counties-this barrier significantly impacts our goal of keeping members at home. The best strategy we can employ to meet our objective is in creating a strong, flexible, close-knit network of Providers while maintaining a good relationship with members and their family. CHS contracts with all available agencies and these agencies employ family members.

Case Managers are the binding agent that makes this strategy possible. They are the gatekeeper and facilitator, care coordinator and service broker. The goal is to provide our members the necessary supports to allow them to maintain their dignity and independence in the most appropriate and least restrictive setting that can meet their needs. This process will help to improve outcomes and promote independence and individuality, while also containing costs. The process involves a review of the ALTCS member's strengths and needs by the member, his/her family or representative and the case manager. The review should result in a mutually agreed upon, appropriate and cost effective service plan that meets the medical, functional, social and behavioral health needs of the member in the most integrated and least restrictive setting. The case manager must foster a person centered approach and maximize member/family self-determination while promoting the values of dignity, independence, individuality, privacy and choice. The case manager and member must mutually plan so that the member's preferences, beliefs, needs, culture and language are incorporated into the member's individualized care plan. The member, family, and/or significant other are partners with the Case Manager in the development of the plan of service.

Through this process, members remain in their home until their needs exceed the capacity of the support network.

Another strategy we employ to keep members in home versus placing them in a facility is by educating members and providers Safety in the Home. The Member/Provider Council meeting is used as an educational forum to express the importance of keeping members at home and how to keep them safe. Topics range from regular eye check ups, lighting in the home, proper use of chairs (not as a ladder), exercising, medications and side effects. This information will be distributed to members via the newsletter this next spring and also published in the provider newsletter in hopes of encouraging providers to talk to their patients.

CHS has also amended contracts or negotiated letters of agreement with providers to increase the reimbursement levels for members with complex or specialized needs to help members stay at home rather than placing them in a SNF or ALF. As an example, CHS previously had a member who desired to remain at home. As such, CHS has three separate shifts including early morning and late evening shifts to assist the member allowing her to remain in her own home versus placing her in an assisted living or skilled nursing facility. There are other members that we accommodate in this fashion to allow them to remain in home as long as possible.

At times, a member's level of care may decrease significantly requiring that they be placed in an ALF or SNF. Rather than permanently placing members at the facility, a case manager may place the member under respite care or for a short term basis with the goal of stabilizing their health through proper diet, therapies and other services offer by the facility and then returning them to their home. This may take a few weeks to a month and helps members get back on their feet and strong enough to remain at home.

Other methods may include transporting a member for outpatient wound care or infusion therapy rather than placing them in a facility for services.

A strategy CHS may employ to return members from ALF or SNF settings is accomplished through the periodic reassessment of a member's level of care for those members residing in ALF or SNFs. If a case manager identifies that a members level of care has improved a feasibility study shall be conducted to determine if a member has the support system in place to return to an in-home setting. If this is determined feasible, the case manager will coordinate services to reintegrate the member into an in-home setting.

18 (ALTCS Only) A Contractor who has greater than 25% of their members residing in an Alternative Residential Setting (ARS) per GSA shall develop an action plan that identifies approaches to make placements in in-home settings rather than ARS. The plan must be continuously evaluated for effectiveness and revised as needed. A comprehensive report must be submitted to AHCCCS 15 days after the end of each quarter until the Contractor has less than 25% of their members in ARS for four consecutive quarters. A plan must be developed if a Contractor has two consecutive quarters of 25% of their members in a GSA residing in ARS.

At this time CHS has approximately 101 members in assisted living facilities located throughout Cochise, Graham and Pima Counties. This accounts for 18.63% of the HCB membership population (542 as of November these are our most recent figures) and does not exceed the 25% limitation set forth in AHCCCS policy. CHS will employ a proactive strategy to ensure that the ALF placement population does not exceed 25% through coordinated efforts between Case Management and Provider Relations/Contracts Departments. This is relatively simple to track based on mechanisms currently in place. The provider relations/contracts department maintains the responsibility of calculating a member's room and board and keeps track of all ALF placements. CHS Provider Relations Staff will proactively monitor the percentage of members placed in ALF versus the total HCB population to prevent an ALF membership greater than 25%. ALF placements shall be monitored on a quarterly basis (or more frequently as deemed necessary) and information shall be presented to the CHS Leadership Team during the periodic bi-monthly meetings and shall be kept as a standing agenda item. In addition, CHS will also add this as a topic for the monthly Quality Circle Meeting as a standing agenda item as a proactive approach to make placements in in-home settings rather than alternative residential settings.

Another proactive strategy is accomplished through the periodic reassessment of a member's level of care for those members residing in ALF or SNFs. If a case manager identifies that a members level of care has improved a feasibility study shall be conducted to determine if a member has the support system in place to return to an in-home setting. If this is determined feasible, the case manager will coordinate services to reintegrate the member into an in-home setting.

19. A listing of Assisted Living Facilities for which the Contractor has already obtained a waiver from the Single Choice Occupancy requirement. Listing must include the name of the facility and the date of the waiver approval. (See Attachment A) See attached.

20. A listing of nursing facilities who have withdrawn from the Medicaid Program but are still being utilized by the Contractor. The listing must include the name of the facility and the number of residents the Contractor has in each facility. (See Attachment B) See attached.

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The plan must include answers to the following questions:
a. (**Acute Only**) How does the Contractor assess the medical and social needs of new members to determine how the Contractor may assist the member in navigating the network more efficiently?
b. (**Acute Only**) What assistance is provided to members with a high severity of illness or higher utilization to better navigate the provider network?
c. (**Acute Only**) How does the Contractor support the Graduate Medical Education (GME) programs within its contracted GSA(s) and pursue contracting opportunities with graduates and providers that are opening new practices in, or relocating to, Arizona, especially in rural or underserved areas?
d. (**Acute Only**) Describe the Contractors process to increase provider participation in Baby Arizona.
e. What interventions has the Contractor implemented to reduce avoidable/preventable ER utilization? What was the outcome of those interventions?

1. Physician coverage/call availability after-hours and on weekends. The CHS network has one contracted physician who provides services for members residing in SNFs and ALFs in Sierra Vista, Douglas, and Benson. In addition this physician and allied health professionals make home visits for members located in the Sierra Vista area. There are two Tucson physician groups who provide services for members residing in SNFs and ALFs in Pima County. Chiricahua Community Health Center, offers 24 hour provider on call services and operates healthcare facilities in Bisbee, Douglas and Elfrida. In addition, this physician group offers weekend care on Saturday from 9-3 in Douglas and Bisbee .

2. Same day PCP appointments. Same day appointments are based on urgency. The member describes the medical need for same day appointment and PCP office assesses whether the provider should see the patient or refer to the emergency room.

3. Nurse call-in centers/information lines. An information call line is available 24-hours per day, 365 days per year. A nurse is available to give direction to the members upon request. The CHS M/UM nursing staff rotates on call coverage throughout the year.

4. Urgent care facilities. Sierra Vista is the only major population center to have urgent care facilities. Hours of operation are between 5:00 p.m. and 9:00 p.m., Monday through Friday and 10:00 a.m. to 4:00 p.m. on Saturdays, Sundays, and holidays. However, weekend appointments are available from 9:00 am to 2:30 pm in Douglas and Bisbee in PCP office.

5. Monthly Report of ER repeat visits. Medical & Utilization Management Division does a Monthly Report of ER repeat visits. The information is given to the specific Case Manager and PCP for any member with repeat ER visits. The Case Manager works with the member/family and/or PCP to develop a corrective action plan to avoid inappropriate utilization of the Emergency Room.

6. How are members educated about these options? There are many avenues of information for the member including their Case Manager, the Newsletter, the Handbook, the website, and their PCP.

7. Outcome of those interventions? CHS monitors members that have three or more ER visits and/or Admissions within a 3 month period. The report also monitors PCP's with 3 or Members with Emergency Room Visits and/or Admissions within a three-month period. In addition, CHS monitors Nursing Homes with 3 or more Members with Emergency room visits in a 3 month period or 3 or more admissions within a 3 month period. A study is conducted annually over a 12 month period and the finding revealed a significantly less number of repeat ER visits and multiple admissions compared to the previous year
Repeat Emergency Room and Admission Report is attached. A summary of findings for 2009-2010 are noted per quarter in the following table

REPEAT ER/ADMISSIONS VISITS

Oct. 01/09-Dec. 31/09	Jan. 01/10-Mar. 31/10	April 01/10- June 30/10	July 01/10 – Sept. 30/10
# Members with 3 or more ER Visits: 5 # PCPs with 3 or more members with ER Visits: 1 (P patel) # NFs with 3 or more members with ER Visits: 0 #ALF's with 3 or more members with ER Visits: 0 # Members with 3 or more Admissions: 4 # PCPs with 3 or more members with Admissions: 0 # NFs with 3 or more members with Admissions: 0 #ALF's with 3 or more members with admissions: 0 Members presented with Concerns: none	# Members with 3 or more ER Visits: 5 # PCPs with 3 or more members with ER Visits: 0 # NFs with 3 or more members with ER Visits: 0 #ALF's with 3 or more members with ER Visits: 0 # Members with 3 or more Admissions: 2 # PCPs with 3 or more members with Admissions: 0 # NFs with 3 or more members with Admissions: 0 #ALF's with 3 or more members with admissions: 0 Members presented with Concerns: none	# Members with 3 or more ER Visits: 7 # PCPs with 3 or more members with ER Visits: 0 # NFs with 3 or more members with ER Visits: 0 #ALF's with 3 or more members with ER Visits: 0 # Members with 3 or more Admissions: 0 # PCPs with 3 or more members with Admissions: 0 # NFs with 3 or more members with Admissions: 0 #ALF's with 3 or more members with admissions: 0 Members presented with Concerns: none	# Members with 3 or more ER Visits: 9 # PCPs with 3 or more members with ER Visits: 0 # NFs with 3 or more members with ER Visits: 0 #ALF's with 3 or more members with ER Visits: 0 # Members with 3 or more Admissions: 0 # PCPs with 3 or more members with Admissions: 0 # NFs with 3 or more members with Admissions: 0 #ALF's with 3 or more members with admissions: 0 Members presented with Concerns: none

Report conclusions: Please refer to the attached ER Summary Report for 2009-2010.

One final note, after speaking with a case manager recently it is noteworthy to mention his specific interventions for a member who was chronically in the ER the previous year. The member would constantly call for heart palpitations or chest pain. The case manager decided to employ a model where he increased home health nursing and added counseling services recognizing that this would perhaps reduce the number of ER visits. The results were dramatic. The member has only had two hospitalizations this year and the number of calls or use of the ER otherwise reduced to zero.

f. Are members with special health care needs assigned to specialists for their primary care needs? If so, what general criteria are used to determine if a member should be assigned in this manner?

Members with special health care needs are assigned to specialists for their primary care needs. The CM assessment tool is used to evaluate all the medical needs of a member. From this evaluation tool and the member's PAS, a CM would identify the need to assign a member to a special health care provider for their primary care needs. Examples of ALTCS members who are assigned to specialists are: pediatrics, maternity, cancer patients, and HIV/AIDS patients.

g. What are the most significant barriers to efficient network deployment within the Contractor's service area? How can AHCCCS best support the Contractor's efforts to improve its network and the quality of care delivered to its membership?

The vast geographic area combined with the limited number of Primary Care, Specialty Physicians, Behavioral Health providers and skilled nursing facilities are major barriers for network development.

Specifically there is a serious shortage of providers in the Greenlee County area. Most services for Greenlee residents are rendered in Graham County. Currently the only services that are available in Greenlee County are primary care, transportation, and home services. However, at time members utilize the services offered through Gila Health Resources on a case by case basis or thru emergent care otherwise services are delivered through the Graham County network.

Another significant barrier is the difficulty in maintaining an adequate network of Licensed Residential Contractors with AHCCCS Identification numbers. CHS attempted to utilize a department within Cochise County as a resource for this however this was declined by the County Administration.

CHS would also like to note a barrier we have experienced in terms of coordination of care for members with behavioral health needs. When we place our members out of area (mostly in Tucson), we are unable to access T36 services and general mental health services through the licensed mental health agencies contracted with CPSA, the Regional Behavioral Health Authority (RBHA). Multiple attempts have been made to set up third-party contracts with the RBHA providers in Tucson and with our local RBHA provider. Update-The Director has been negotiation with Cenpatico for Title 36 services in anticipation of their start date in our county as the RBHA in December.

In the past, our local Behavioral Health Provider SEABHS provided these services through their Outsource D/C Planner, although it was always done reluctantly and with much prodding. In 2009, SEABHS declined to become the supervising and treating agency for two members that were petitioned in Tucson and put under court-ordered treatment. In the first case, the court order had to be dismissed due to lack of a treating agency. CHS again tried to set up contracts for these services with the Tucson agencies, including asking for assistance from the RBHA, CPSA. In the second case, SEABHS had prepared and signed off on the Outpatient Treatment Plan, but they have filed 2 motions with the court recently to be removed as the treating agency. A third hearing has been scheduled to address this.

SEABHS maintains that when we place our members in Tucson, they are no longer under their jurisdiction. At the same time, the RBHA providers in Tucson (La Frontera, Cope and Codac) maintain that our members do not fall under their jurisdiction and/or they are already maxed out and/or they need permission from CPSA. CPSA maintains that they do not need their permission to contract with us, and have no authority to assign a provider to serve our members.

The real (underlying) issue appears to be the long-standing divide between the RBHA's and ALTCS. ALTCS receives Title XIX funds directly from the state, as do the RBHA's. Therefore, CPSA maintains that our SMI members are not eligible for enrollment through them. This was made clear by the CPSA representative at the recent mental health hearing noted above.

In the past the Director contacted PHS to set up an inter-agency agreement for services in Tucson, as they are a licensed mental health agency. Unfortunately, at this time they are short a psychiatrist and unable to serve our members, but may be able to assist us in the future.

Neither CHS, our County Attorneys, or the Superior Court has been able to resolve this issue.

Update—it is our hope to bridge this gap with a new foundation beginning with Cenpatico. As stated we are in contact with them not only for Title 36 services but also for behavioral health services in our GSA. They have stated that more providers will be available and CHS is seeking to contract with these providers once the new contract is in effect in December.

(How can AHCCCS best support CHS' effort to improve its network and the quality of care delivered to its membership?

CHS would like to take this opportunity to once again thank AHCCCS for their continued support over this past contract year. Each time an issue, obstacle or barrier arose, AHCCCS is always there to help us along the way and we truly appreciate your guidance and mentoring efforts.

h. What interventions has the Contractor implemented to address and reduce no-show rates and how is information collected to assess the efficacy of these measures?

CHS employs a variety of mechanisms to address and reduce no-show rates. Mechanisms include Member and Provider Surveys, Expressions of Dissatisfaction, Quality of Care Concerns, analysis of provider and member utilization reports for transportation services, provider monitoring. In addition Quality Circle and Inter-reliability work groups at CHS are methods utilized to identify any issues with transportation services including no show rates or network issues. All of these mechanisms include year end reports that would potentially identify any issues or trends with transport services. The analysis of this data is presented as part of the QM/UM Plans submitted in December of each year.

Interventions and education are accomplished through periodic mailings to members such as the members newsletter and member handbook that contain articles about the importance of keeping medical appointments and responsibility of notify CHS when there a member intends to cancel a service that may affect transportation services.

CHS has implemented a Process Improvement Project to measure the effectiveness of transport services with the overall goal of improving quality and utilization of services. This study resulted from an increase in concerns in 2003/2004 and has been studied since this time. The final measurement report for 2006-2007 noted that there has been an overall improvement in transportation services with only 12 reported problems compared to 7450 total transports. The baseline period from 10-1-04 to 9-30-08 reported 42 transport issues from 6389 transports. .Reports are available upon request. No further studies have been conducted.

Part III - LONG TERM GOALS

Overall our long-term goal is to contract with all available providers within each GSA and improve quality of care to CHS members while maintain fiscal responsibility through the implementation of focused work groups designed to streamline business operations at CHS. At this time we are confident that network meets the needs of members, however, we would like to reduce the number of instances where members are transported out of the GSA to receive services. As specialty services become available in our areas either through new office locations or monthly clinics, CHS will contract and add the providers to our network.

CHS will continue efforts to contract with Gila Health Resources to build up the network in Greenlee County. Although not a long distance from Graham County members should have the choice to receive services in their home town rather

than spending the day going into Safford- **Update 2011**-CHS has submitted a Letter of Intent with this provider results are pending at this time. In the interim, CHS does allow OON requests for services with Gila Health Resources whenever the provider is willing to render services and it is deemed medically appropriate and a benefit for the member.

Workforce development is also an important long term goal. Our efforts include building a strong network of providers to allow members to remain in-home rather than placing them in an ALF or SNF. CHS also maintains a goal of education the community about direct care employment opportunities through public forums such as participation in DCW workshops, county website education, education through our providers during monitoring and through the member/provider council meetings.

Continued recruitment and development efforts for the establishment of a Skilled Nursing Facility in Cochise County with a specialty in behavioral management much like the facilities already established in Pima County. CHS is working with Quiburi Mission in Benson on this project. ***Update 2011**: as previously mentioned, Quiburi Mission broke ground this year on the expansion project for behavioral management and dementia services at the skilled nursing facility and CHS is now contracted with the provider for the secure unit. The unit is specifically for Alzheimer's/Dementia. In addition, CHS added two Skilled Nursing Facilities in the Maricopa County area whose has the capacity for behavioral management services and one Assisted Living Facility with the same speciality.*

To Contract with University Physicians to provide Specialty Services in Cochise County to include Psychiatry, Cardiology, Pediatric Cardiology, Cardio-thoracic Surgery, Endocrinology, Vascular Surgery, Neurology, Nephrology, Perinatology, and Pediatric Genetics. **Update: CHS has continually maintained communications with the contracting department of UPH in hopes of securing an agreement with this organization. CHS has sent out a contract to UPH for all the services they offer.

****2011 UPDATE**---Between the months of November to March CHS continued the contractual negotiation process with UPH and succeeded the approval of a Letter of Intent. In addition, CHS agreed on a reimbursement methodology for all services offer by UPH such as UMC and UPH Hospitals and all Primary Care and Specialist Services. This is a very exciting accomplishment as it adds hundreds of providers, inpatient and outpatient services (including various Ambulatory Surgical Centers) to the CHS network in both Cochise and Pima Counties.

**** 2011 UPDATE**--CHS is already contracted with the St. Mary's and St Joseph's Hospital however in 2011 CHS began negotiations with the entire Carondelet network to include all hospital services, Inpatient Behavioral Health Skilled Nursing Services and Ancillary services including Ambulatory Service Sites. Here again, CHS has added many more providers to the CHS network making it the largest in our 18 years of operations.

Between the UPH Contracts and The Carondelet Contracts, The CHS has accomplished the largest network in our 18 years of operations. More shall be reported on these contracts, as they are works in progress, the next network development report due November 2011.

****2011 Update**-Adult Day Health (ADH) Services are listed in this document as a network gap based on the lack of ADHS licensed ADH providers in Cochise, Graham or Greenlee Counties. Recently, CHS received a Letter of Intent (LOI) from Abrio Family Services for Adult Day Health Services. With this LOI, it is our mutual goal to expand services to our geographic services areas. This will be a work in progress and CHS will report our developments/accomplishments with the next Network Development Plan. CHS has also reached out to Graham County ARC and Douglas ARC with the same goals.

****2011 Update**---One final note CHS would like to mention our efforts with University Physicians Care Advantage (UPCA). We have begun negotiations with UPC for the purpose of collaboration between our organization and the UPCA Medicare Advantage Plan for dual-eligible members. This is a work in progress but CHS thought it noteworthy to mention our efforts and goals in partnering with UPCA this contract year

COCHISE HEALTH SYSTEMS
NETWORK DEVELOPMENT AND MANAGEMENT PLAN
NOVEMBER 15, 2010

Paula Saroff-- Submitted Electronically
Chief Operating Officer

Mary Gomez, MN, Director
Cochise Health Systems

Rhema Sayers, M.D.
Medical Director
Cochise Health Systems

______________________________ Date: November 15, 2010

COCHISE HEALTH SYSTEMS
NETWORK DEVELOPMENT AND MANAGEMENT PLAN
NOVEMBER 15, 2010

NETWORK DEVELOPMENT AND MANAGEMENT REPORT
ATTACHEMENT A

PROGRAM CONTRACTOR: Cochise Health Systems**DATE:**November, 15, 2010

CYE 10 ALTCS Contract, Paragraph 28, Network management and Development bullets 14, 15, and 16 require the following items to be listed:

15. Non-Medicare Certified Home Health Agencies (HHA):

	Non-Medicare Certified HHA Name	AHCCCS ID#	Type of Services Provide	Geographic Area Served
1.	Aristocare Home Health Services	870932	Personal Care, Homemaker, Respite Attendant Care, Skilled Nursing Svcs including Med Set ups.	Cochise County
2.	Ascension Senior Care Services	431246	Nursing and Direct Care	Cochise County
4.	Assurance Home Care	419287	Nursing only	Benson, Tombstone, Whetstone areas only
6.				
7.				
8.				
9				
10				

Use of a non-Medicare Home Health Agency(ies) is in compliance with AMPM Chapter 1200, Section 1240, ALTCS Services/Settings, Home Health Services.

ATTACHMENT B

18. ***List of Assisted Living Facilities for which the Contractor has already obtained a waiver from the Single Choice Occupancy requirement. Listing must include the name of the facility and the date of the waiver approval:***

	Assisted Living Center	AHCCCS ID#	City / Area Served	Exception Period (10-08 to 9/09)
1.	Cypress Inn	822131	Douglas Arizona-Serves all of Cochise County	Feb 2007
2.	Villa Vista	817455	Sierra Vista, Arizona-Serves all of Cochise County	Feb 2007
3.				
4.				
5.				

19. ***List of nursing facilities who have withdrawn from the Medicaid Program but are still being utilized by the Contractor. The listing must include the name of the facility and the number of residents the Contractor has in each facility:***

	Nursing Facility	AHCCCS ID#	City / Area Served	Number of Residents
1	NONE.			
2				
3				
4				
5				
6				
7				
8				
9				
10				

COCHISE HEALTH SYSTEMS PROVIDER NETWORK SUBMISSIONS # E37

As an established incumbent Program Contractor for GSA 46 – Cochise, Graham, and Greenlee Counties - CHS is exempt from this requirement.

It is the philosophy of CHS to build strong relationships and communication lines with our providers by personally expressing an interest in their operations rather than being just a voice on the phone. As a Program Contractor with 18 years of experience, CHS has an established process to communicate with the provider network to explain the standards for the program, changes in laws, regulations and changes in subcontract requirements. The Provider Relations/Contracts Dept, as provider liaison, is responsible for developing and maintaining that positive and open communication line with providers to promote a collaborative effort in the delivery of services to our membership while ensuring that providers are kept apprised of any change to the laws, rules, or contract requirements.

CHS disseminates all programmatic changes (written or electronically) to subcontractors in accordance with AHCCCS policy. This may include, but is not limited to, changes to policy/procedure, subcontract updates, termination of contract, information on chronic care/disease management or other information as required by AHCCCS contract. All programmatic changes that affect the provider network are issued quarterly, or more often as necessary, beginning October first of each year through Program/Provider Manual updates. This includes, but is not limited to, new and/or revised policies and procedures, provider network changes, and revisions to AHCCCS policies or Minimum Subcontract Provisions. All changes required as a result of AHCCCS contract amendments are issued through administrative amendments/contract revisions to the affected providers/contract(s), and/or Provider Manual updates when appropriate. CHS distributes the quarterly updates via US Mail or electronically (upon request). In tandem, The Provider Manual and other pertinent programmatic data are also updated and maintained on the CHS Website. The CHS website content is designed in accordance with AHCCCS specifications. Providers may access the CHS website for information such as (not all inclusive) the Formulary (both Searchable and Comprehensive Listing), Provider Manual (containing all services requiring prior authorization), Provider Directory (including specialists for referral), Performance Measure Results (Contractor-Specific and AHCCCS Program), Medical Determination Criteria and Practice Guidelines.

Initial Training/Provider Education: The provider orientation is conducted within 120 days of the contract start date and includes, but is not limited to, a description of CHS and its operations, a review of the contract terms and covered services, and a review of the Provider Manual. For educational and informational purposes, training and/or review sessions are offered to all providers who may experience personnel turnover or who may need additional assistance. Training may also be offered to providers when there are programmatic changes that affect the provider's contractual obligations such as changes to authorization process, billing, grievances, etc. Contracts staff maintain records of training in the provider contract files. The CHS Case Management Department also hosts monthly meetings with Home and Community Based Providers. These meetings are member-centered case management meetings to ensure consistency of services, help determine availability and accessibility of services. This also assists CHS in determination of the adequacy of the network and quality of services to members as well as strengthening CHS' relationship with our provider network. The CHS Claims Educator also provides education to providers whenever deemed necessary. A provider may request the training or education that may stem from a trend recognized in the claims dispute process or medical review of claims.

Provider Manual: CHS distributes the Cochise Health Systems' Provider Manual to subcontractors and providers that may submit claims and/or encounter data. The Policy manual contains at a minimum, all information as required by AHCCCS policy, including but not limited to, ACOM 416 **Provider Network Information Policy**. Upon execution of their contracts, all providers will be given a copy of the Cochise Health Systems' Provider Manual, which contains established/existing policies and procedures that describe program requirements. Some examples for reference include: requirements for prior authorization, claims/billing submission, claims medical review process and information on fraud and abuse, a description of Cochise Health Systems' organizational structure and instructions for contacting Cochise Health Systems. (Entire Provider Manual is available upon request.) From the onset of a contractual relationship, the contractor is made aware of availability of the Provider Manual via the CHS website (through various contacts with the provider during monitoring, etc.). Providers may at any time request a copy of the CHS provider manual and CHS may also distribute to providers that submit claims and/or encounter data to CHS per ACOM policy. This Manual is distributed in hard copy or electronically as per Provider preference.

Newsletters and Mailings: The CHS Newsletter is used as a training tool to reiterate and reinforce changes in rules or requirements from AHCCCS that may also have been relayed in the previous Provider Manual Update, contract amendments, or communication directly from AHCCCS or CHS. The newsletters are also used to relate new information in the interim of the quarterly provider manual updates, to relay results of provider surveys, to highlight changes to the network or changes to policy/procedure and information on CHS staff. The Newsletter generally has information to educate providers (but is not limited to) on Fraud and Abuse, Cultural Competency and Claims Education or other topics that may have been identified and trended from the Grievance System process for example. It may also serve to notify/educate providers of services offered by CHS, such as claims/eligibility inquiry or electronic funds transfers. CHS Newsletters are also posted on the CHS Website.

CHS uses provider group specific mailings for certain information. For example, the Formulary is only mailed to physicians, nursing homes and pharmacies, as they are the only providers that use it. Any rule change that applies to a specific provider group would be disseminated to that group alone, then again in the quarterly Provider Manual Update and perhaps repeated in the Newsletter. All of these updates are also available on the CHS website.

Individual mailings and calls are made to providers who have specific questions, concerns or issues that do not apply to similar providers. Individual communication may be initiated because of communication with various sections of CHS when they have identified problems with provider processes. Contact is then made with the provider to offer additional training to resolve the problem.

Provider Monitoring: is another mechanism utilized to communicate with providers. On-site facility assessments are conducted in accordance with AHCCCS policy 920 of the AMPM. Monitoring assessments include (but are not limited to) a site review, review of providers' policies and procedures including policies on drug screening, fraud/abuse, federal false claims act, emergency protocols and personnel records (on selected providers), verification of current licensure, ~~and~~ most recent State survey results in relation to the contracted service, and verification of CHS provider manual maintenance. In addition, provider data received/maintained internally by CHS is reviewed by the surveyor for any grievances, claim disputes, quality of care concerns, and/or any other internal data that may be relevant. Any changes regarding contractual or program requirements are also conveyed during the monitoring visits. Again, communication is encouraged with our providers. If additional questions or comments arise after our visit, we ask providers to contact us at any time, preferably at the time problems arise and not months later. If issues with other sections of CHS are identified during the monitoring visit, Contracts staff refers the information to the appropriate staff member for action or resolution. This manner of communication with our providers also assists CHS in the development of training sessions with our providers by identifying areas of concern or confusion. Issues raised by a specific provider in a monitoring visit may be addressed with similar providers through in-service or training sessions and used as a mechanism to maintain continuity of provider services and to disseminate information to the Network of Providers. Providers are encouraged to contact the CHS Administrative Office with questions or concerns at any time. During training and in-service sessions, they are also made aware of their grievance, claims dispute and hearing rights. This information is also identified in the Provider Manual, their contract, via notices mailed with the remittance advice, and/or sent with claims that have been denied.

If a need for improvement is noted during an on-site review, a plan of correction is requested from the provider. Issues that are quality of care concerns are forwarded to the Medical/Utilization Management Section who then works with the Provider to develop a plan of correction. The Contractor is then specifically monitored for compliance according to their plan of correction. Results of the reviews are forwarded to the provider and individual survey forms and subsequent documentation is filed in the Provider Monitoring File and Provider Contract File. If issues are identified prior to the monitoring visit as something problematic, it is addressed personally in the visit to ensure the provider understands and is able to comply with the requirement. Internal communications with CHS staff members are often used as a method to identify providers that may be experiencing problems or difficulties that may range from coordination of services to claims submission. As an example, prior to on on-site visit, staff will survey the claims department to determine if there are any issues to address with the provider such claims submissions. During the visit, staff may offer training by the Claims Educator as a resolution to assist the provider in claims submissions and subsequently reduce the frequency of returns/denials. Issues brought up by a specific provider in a monitoring visit may be addressed with similar providers in future visits to help prevent a trend and for continuity in communication amongst providers.

Cultural Competency: During monitoring, Contractors are surveyed to ensure they have the ability to provide care for and accommodate members with different ethnic backgrounds, such as availability of bilingual staff or intake forms in different languages. CHS views provider monitoring as a tool to promote cultural awareness. On-site reviews are used to identify communication barriers with members and possible means of resolution. This may include the use of other more appropriate providers with diverse linguistic skills and cultural understanding or the use of translation services available to CHS members and providers. CHS offers providers a Cultural Competency guide and this information is also available to all providers on the CHS website. In addition, CHS offers a cultural competency in-service once a year to all providers.

Committee Participation by Providers: Providers of various services are represented by participation in the CHS Medical Utilization Process Improvement Committee (MUMPIC), and the Member/Provider Council, both of which can be used as forums to communicate with the provider network.

The MUMPIC is represented by various community providers, healthcare professionals and organizations. The Committee meets quarterly and reviews most aspects of CHS operations. It serves to provide a forum for each department within CHS to discuss various topics with the committee and education providers regarding any changes in law, rules, regulations or changes to the program.

The Member/Provider Council is a communication forum for both providers and members. The intent of this Council is to provide a bridge or link between providers, members, and CHS staff to promote a collaboration within our network and organizations. CHS may utilize these meetings to communicate with Providers and Members and offer education as well as receive input on ways to improve our program operations. It is a collaborative effort of CHS, Network Providers, CHS Members, their families or significant others with the goal of enhancing the service delivery system in Cochise, Graham and Greenlee Counties. The MUM Section is responsible for developing the Plan and coordinating the meetings for the Member/Provider Council. Other CHS staff leadership may participate as panel members and provide input on CHS policy, programs, covered services, additions to the Provider Network, and the delivery of services. The meetings are also used as an opportunity to obtain information on the current status of network from both the provider and member's perspective, feedback on any possible gaps or limitations and to obtain suggestions for new providers or services that could be added to the Network. The Provider/Member Council meets quarterly and rotates the meetings to different locations to allow easier access to meetings and greater participation by members, families and providers in this large rural area. Members may participate telephonically if they are physically unable to participate and desire to do so in this manner. CHS-continues to explore the possibility of offering greater participation through teleconferencing for members and families expressing an interest but unable to travel to attend the meetings.

Contract files: Documentation of all Provider Communications is kept in the Contract and/or Monitoring File including but not limited to the Provider Manual, quarterly updates and notices regarding any programmatic or contractual changes. Provider inquiries, complaints and requests for information outside of the claim dispute process are separately logged in the CHS Call Tracking system (custom application for the tracking of provider communications). Prior to the distribution of the update on October first of each year, the draft Provider Manual is submitted to the Cochise Health Systems Medical Director and the Director for review and approval. Provider orientation meetings are conducted with each new provider by the Contracts Staff and with other Sections of CHS whenever deemed necessary (as previously stated).

Cochise Health Systems (CHS) utilizes many forums built within the framework of the organization to manage the network and communicate identified issues within our organization. CHS is comprised of distinct but interlaced departments that work together to provide comprehensive quality healthcare to those in need. Staff in these departments work together to continuously shape tomorrow's managed healthcare and promotes the values of choice, dignity, independence, individuality, privacy and self-determination. These departments are Case Management, Finance, Claims Adjudication, Encounters, Provider Relations/Contracts (PR/C) Management, Medical Utilization and Quality Management and Administration. Through a collaborative team effort within CHS, CHS has developed a strong yet flexible, diverse network as a foundation for the delivery of medically necessary covered services in a timely, cost-effective manner, while maintaining the highest quality of care. All staff members take pride in our organization and have a vested interest in ensuring the efficacy of the network for both providers and members. This is evident by the well-established relationships, through the 18 years as a Program Contractor, with providers, members and internally with fellow coworkers who share the same goals, mission and vision of AHCCCS. CHS uses information from all departments to identify opportunities for improvement in our provider network and service delivery.

Interdepartmental Collaboration-CHS has in place an interdepartmental policy that serves to promote coordination and communication across disciplines and departments within CHS. This is accomplished specifically through regular meetings of the Leadership Team, Quality Circles, Inter-rater Reliability Workgroup, and other workgroups as needed. The purpose of this policy/process is to improve on-going communications among CHS departments with particular emphasis on ensuring coordinated approaches with medical management and quality management. These efforts begin with ensuring that the network is adequately managed and that provider issues are identified communicated and resolved in a timely and efficient manner.

Leadership Team-this team meets twice per month or more frequently (as deemed necessary) to maximize the exchange of information between the Director, department leaders and staff within CHS. Agendas are prepared so that each team member is given the opportunity for input regarding the organization and sharing of information regarding members, providers, the network, claims processing, encounters, etc. These leadership meetings give each supervisor the opportunity to bring forth any issues as they arise, foster ongoing communication and identify positive solutions to challenging issues. As an example, CHS experienced issues with a Durable Medical Equipment (DME) Provider. The issue was discussed with the leadership team as the provider failed to deliver products to members in a timely manner. The PR/C Supervisor discussed the contractual obligations with the team and from this point, an entire conversation ensued with the team for resolution. The team then developed a plan of action regarding the network with a member-centered approach. This approach was to send out a supplemental bid for DME services while simultaneously working with the provider to request a corrective action plan through the M/UM department/Quality of Care Concern (QCC) process. The process included following the provider's progress and determining if there was an improvement in the provider's performance. Since there was no improvement in this case, CHS sought additional providers to supplement the network and redistribute the workload to more than one provider. This helped tremendously in the timeliness of service provision by easing the workload from one provider and redistributing it among other providers. By supplementing the network, CHS focused on the member's continuity of care by not terminating the contract but through expanding services. Ultimately, when issues of this nature occur, the provider's contract may need to be terminated. Prior to that however, with a team approach, CHS seeks to communicate with our colleagues to effectively-solve any issues while focusing on the members' needs. At no time would CHS jeopardize member care if a provider's performance is such that members are going without services. CHS would always determine the most appropriate course of action given the nature of the situation and specific circumstances. The Director and Department Leaders are also designated as the Network Management Committee. This topic is a permanent agenda item to discuss ongoing network issues, including additions, deletions, deficiencies and plans of action when needed. This Committee acts in an advisory capacity to the Network Task Force as defined in CHS Network Development and Management Plan.

Network Task Force-The CHS Network Task Force monitors and analyzes the provider network to ensure compliance with CHS quality standards, compliance with ALTCS Minimum Service Requirements, recommends strategies to strengthen the provider network and reviews incoming applications/credentials from providers who wish to join the network. Annually, the Task Force reviews utilization of services and projects the anticipated utilization of services based on characteristics of population and its health care needs. The bi-monthly Leadership Team meetings serve as a forum for supervisors to discuss Network issues for presentation to the Medical Director as needed. The Task Force is chaired by the CHS Director and consists of the CHS Leadership Team. Representatives are responsible for presenting information based on their position within CHS. For example, the M/UM Manager

presents provider QCC for possible corrective action based on contractual specifications and member/provider survey analysis. The Member and PR/C Supervisor presents information regarding network management that includes: the ALTCS service site requirement, the status of the current contracted network, and the periodic results of the call tracking system to ensure that provider call, inquiries, complaints and/or questions are responded to timely and appropriately resolved. This communication is also used to analyze for any potential trends/issues within network. The Case Management Supervisor presents information regarding her day-to-day experiences, information regarding member-provider relations, and delivery of care. This would include (but is not limited to) member satisfaction with a particular provider, providers' ability to coordinate services with other providers or suggestions on new specialists or other providers for the network.

Quality Circles-are a process CHS has in place to allow for the continuous communication of information between all CHS Divisions, especially for member care planning, network management and addressing opportunities for improvement in all functional areas. Each Quality Circle Team meets monthly and has a representative from each department within CHS. The circles are separate from the Leadership Team and are designed to encourage participation by all staff members. Agendas are prepared where each team member is given the opportunity for input regarding the organization and sharing of information about members, providers, the network, claims processing and encounters (examples not an all inclusive listing). One action log is maintained and evaluated by the Director/Leadership team to identify any issues/trends through the multidisciplinary staff Quality Circle meetings. The review and analysis process may then include Performance Improvement processes outlined by the Leadership Team and implementation by the appropriate department. For example, if a trend is identified with a provider's billing practices, the Claims Educator and PR/C Manager will offer training to the provider to help improve the provider's compliance with billing requirements. Outcome measures to determine the efficacy of any corrective actions are established to measure-existing systems. This could include, but is not limited to, Grievance System process (i.e., a reduction in the number of claim disputes) or a follow up review of the provider's performance conducted by the Financial Services Manager.

Inter-rater Reliability Work Group-This CHS work group meets monthly (or more frequently if necessary). Its purpose emerged from an issue identified with a particular category of service. CHS identified a 38% increase in authorized attendant care hours without any material changes to member demographics. From this, CHS launched an extensive research study on attendant care services and identified many issues from suspected fraudulent billing practices to an over authorization of services by CHS case managers. This study was eventually presented to AHCCCS and fellow Program Contractors and demonstrates the efficacy of our team work and dedication to the program. CHS learned many lessons from this study and some actions taken included focused meetings with providers to educate them on proper billing practices, implementation of a sanction policy, focused claims review process to prevent overpayments and fraud and member education on proper documentation practices. The work group has analyzed durable medical equipment and supply services to identify any potential areas for improvement and to ensure that member's needs are being met while maintaining fiscal responsibility. The group identified that member supplies were being delivered even when the members were not at home due to hospitalizations. The DME company would have the supply orders generated each month and drop ship to the member's home. Similarly, the group identified that some members did not use the supplies they received but never voiced this so the supplies kept coming each month. As a result of these findings case managers evaluate the DME services each assessment to ensure that members' needs are being met and over-utilization/waste is not taking place. Minutes from the group are available upon request.

Expressions of Dissatisfaction (EOD) and QCC (part of Grievance System process) are tools put in place to respond to member grievances and provider complaints-issues. However, these tools are also useful mechanisms to receive data and feedback and help manage the network. This is a shared responsibility by all staff members with CHS and the process is executed in accordance with AHCCCS policy. Staff training upon hire includes the process for reporting expressions of dissatisfaction and QCC and training is conducted annually thereafter through staff in-services. The information obtained through the analysis of both EOD and QCC is internally reported to the Leadership Team including the Medical Director and the M/UM Process Improvement Committee for action. Through this process and flow of information within the organization, CHS may recognize existing network issues such as a gap, weakness, barrier in a particular area and/or the need to expand network services.

Provider Monitoring is also a mechanism utilized internally by the organization to manage the network, identify provider issues, and communicate those issues with appropriate staff/department for process improvement and corrective action. Each department within CHS plays a vital role in the network monitoring process to identify areas for possible Network Development. These monitoring efforts help identify a provider's ability or inability to provide timely services, or ability to meet the members' needs based on acuity and special needs. Providers are also queried about new providers in the area that may be a potential asset to the network. On-site facility assessments are conducted in accordance with AHCCCS policy 920 of the AMPM and are a shared responsibility between PR/C and

M/UM (M/UM division conducts on-going service reviews and member chart audits at differing intervals). Providers are also surveyed by the staff surveyors for any grievances, claim disputes, QCCs and other internal data that may be relevant to their performance as a subcontractor. Communication is always encouraged with our providers. If additional questions or comments arise during/after the visit, we ask providers to contact us at any time, especially as problems arise and not months later. If issues with other sections of CHS are identified during the monitoring visit, Contracts staff refers the information to the appropriate staff member for action or resolution. This manner of communication with our providers also assists CHS in the development of training sessions with our providers by identifying areas of concern. Issues raised by a specific provider in a monitoring visit may be addressed with similar providers through in-service or training sessions and used as a mechanism to maintain continuity of provider services and to disseminate information to the Network of Providers. Providers are encouraged to contact the CHS Administrative Office with questions or concerns at any time. If a need for improvement is noted during an on-site review, a plan of correction is requested from the provider. Issues that are QCCs are forwarded to the MUM Section who then works with the Provider to develop a plan of correction. The Contractor is then specifically monitored for compliance according to their plan of correction. Results of the reviews are forwarded to the provider and individual survey forms and subsequent documentation is filed in the Provider Monitoring File and Provider Contract File. If issues are identified prior to the monitoring visit as something problematic, it is addressed personally in the visit to ensure the provider understands and is able to comply with the requirement. Internal communications with CHS staff members are often used as a method to identify providers that may be experiencing problems or difficulties that may range from coordination of services to claims submission. As an example, prior to an on-site visit, surveyors will contact CHS claims department to determine if there are any issues to address with the provider. During the visit, staff may offer training as a resolution to assist the provider in claims submissions and subsequently reduce the frequency of returns/denials. Issues brought up by a specific provider in a monitoring visit may be addressed with similar providers in future visits to help head off a trend and for continuity in communication amongst providers.
Monitoring network capacity is an ongoing process designed to ensure reasonable availability of services based on the volume of members using the services. It involves the compilation of input from Network Summary, Grievance System Process, trending, monitoring, staff, provider and member survey data. Multiple providers, or every provider available in an area or service category, are often contracted to ensure sufficient network capacity in these rural areas. Facility (SNF and ALF) capacity and census information is also a helpful tool to manage the network. Waiting lists are also reviewed to determine the need for additional providers. CHS expanded its network of nursing facilities in the Tucson and Maricopa County area in order to ensure member placement at times when a local facility is at capacity or for members with highly specialized needs or rare diagnoses. This helps to prevent any gaps in service and to provide member choice.
Provider and Member Surveys are mailed annually to gather information regarding the network and about the organization. The surveys cover a range of topics from (examples only not all inclusive) satisfaction with services, timeliness of services and satisfaction with individual departments of CHS. In addition, CHS conducts random annual physician accessibility surveys during regular office hours based on standards developed and approved by the Leadership team and Process Improvement Committee. This helps CHS manage the network by ensuring that Primary Care Physician (PCP) appointments including out-of-network referrals, medical services and advice are available to CHS members within the standards established by AHCCCS. This survey feedback helps CHS identify our strengths as wells as areas that may need improvement. The results are analyzed by the Leadership Team and MUM Process Improvement Committee for trends that may lead to provider or internal staff education and overall serve as a tool to improve our operations. The provision of excellent services, as a Program Contractor for 18 years, to our membership and close knit relationships with our providers in this GSA are evident in the survey ratings and results throughout the years.
Utilization reports and statistical analysis-the M/UM Manager and staff conduct monthly reviews of post payment claims reports for statistical analysis and results are presented to the Leadership Team and to the MUM Process Improvement Committee for review and action as deemed appropriate.
M/UM Process Improvement Committee (MUMPIC): Is a CHS subcommittee where results of provider monitoring, surveys and Grievances are reported. The group meets quarterly as a means of verifying stability within the organization and the network and soliciting feedback from the committee. In addition, M/UMPIC reviews QCCs as needed.
Provider Call Tracking- CHS staff track and trend all provider inquires/complaints/requests with the Provider Call Tracking software application. Results of the call tracking system are analyzed by the Leadership Team and process improvement plans are set forth whenever deemed necessary based on the results of the database query results.

Overall, CHS has created many mechanisms in place over the past 18 years of experience that serve to promote communication, collaboration within the organization, network management, and process improvements. Again the efficacy of our performance is evident through our own surveys and those of the State AHCCCS audits.

Cochise Health Systems (CHS) Provider Network Submission # E40

Cochise Health Systems, as an established Program Contractor, has a Provider network that has been evolving over the past eighteen years to include the areas of Cochise, Graham and Greenlee Counties. Strong flexible and diverse Networks are the foundation that supports our continued ability to meet members' needs and honor member choice on both an immediate and long-term basis.

In order to adequately manage the vast network of providers that offer choice to our membership, CHS has implemented policies and procedures to ensure that we maintain those close knit relations with our providers while adhering to AHCCCS policy. CHS staff responds to provider calls within three business days of receipt and resolves and/or states the result of the communication within thirty days of receipt. If the issue is not resolved within thirty days, staff document why the issue was not resolved and the issue must be resolved within ninety days.

CHS staff respond to provider calls in a professional and courteous manner. When staff are responding to written correspondence from providers including emails, staff provides written correspondence that is clear, concise, and professional. No internal emails between staff members are distributed externally to providers or members. At times if deemed necessary, staff may distribute an email to a provider with consent of the Supervisor or the originating author of such correspondence. All email correspondence complies with the HIPAA guidelines and policies.

Provider communications are stored either electronically within the "Call Tracking" software application or documentation is kept with the contract file for that specific provider. "Call Tracking" is a separate database application available to each staff member via computer desktop. Calls/Communications specifically pertaining to a member are documented in that member's file, not through call tracking, i.e., a call from a home care provider to report a member's condition. If the call is specific to the status of an authorization or a topic of that nature, the call is logged in "Call Tracking". Calls are classified according to category in "Call Tracking". For instance, if a provider calls about payment, the call tracking type "payment status" would be selected. When the call is first logged, the staff member selects the new call tab and also enters an acknowledgement date (especially if the call was received via voicemail). If the call is resolved the same date, the staff member then saves the call entry and then selects resolution date. If the call is not resolved, then the next entry is made under the same call using the follow-up tab. Once resolved, the call is marked as resolved using the resolution tab on "Call Tracking".

The Chief Operating Officer utilizes a series of SQL queries or scripts written expressively for extracting data from the Call Tracking database. The information may be pulled in a variety of different ways through the custom SQL queries and is shared with the Leadership Team to analyze and identify any issues or trends. Results of these reports are discussed during the regularly scheduled Leadership Team bi-monthly meetings, as deemed necessary. If an issue is identified by the committee three or more times, it will be considered a trend. A corrective action plan (CAP) or "next steps" will be decided by the Leadership Team. The plan may involve education of the provider, such as billing or prior authorization training. The trend may also involve an internal workflow issue. If this is identified, the CAP will involve actions by the appropriate CHS department. All CAPs resulting from "Call Tracking" will be maintained by the Provider Relations Department for auditing purposes.

This efficacy of this process is monitored through various feedback mechanisms, such as AHCCCS annual audit performance, provider and member surveys, Leadership Team Meetings, CHS Quality Circles, provider monitoring, and the Grievance System Process to include Expressions of Dissatisfaction and Quality of Care Concerns. CHS is confident of its adherence to AHCCCS policy as stated herein and as evident by past Audit/OFR performances, excellent ratings with providers and members through Survey responses, and performance rated during the analysis of the Grievance System Process.

As stated above, CHS has been an ALTCS Program Contractor for eighteen years. Throughout this time we have built very strong ties to our community and most providers and members know us on a first name basis! They never hesitate to call us to address and resolve any concerns they may have and we do pride ourselves on this fact. We are not just a payer source - we are much more and it shows through any of our performance measures.

Cochise Health Systems (CHS) Provider Network Submission # E41

Cochise Health Systems (CHS) maintains a process to ensure that all CHS staff receives the training needed to competently perform their assigned job duties. This includes the requirements for Provider Services staff to receive adequate training to perform duties in Network Development and Management as outlined by AHCCCS Contract and various policies.

CHS ensures that staff members have appropriate training, education, experience and orientation to fulfill the requirements of their position. Initial and on-going training includes an overview of AHCCCS program and policy/procedure manuals. Employees are instructed on how to access information on internet for state and federal regulations as they pertain to the program such as Arizona Revised Statutes, Arizona Administrative Code, and the AHCCCS web page. This includes various policy manuals that guide the daily operations of our organization. An overview of CHS operations is provided to new employees through a CHS custom PowerPoint presentation entitled "CHS 101" for independent review and discussion with Supervisor. In addition, each employee is educated on CHS policies and procedures for processes such as: the Grievance System Process, Quality of Care Concerns and Expressions of Dissatisfaction, Member Appeals and Provider Claim Disputes, maintenance of Provider Contact Logs/Call Tracking, HIPAA regulations, Protected Health Information, Deficit Reduction Act (as provided on the AHCCCS website) and the safeguarding of member confidentiality. All of this information is provided in the CHS New Employee Handbook. This list is not all-inclusive, but gives a general idea of the training for CHS employees to ensure excellent quality services as representatives of CHS and AHCCCS.

The CHS Director is responsible for the annual update of the Business Continuity Plan. The Plan contains, at a minimum, planning and training for: electronic/telephonic failure at CHS's main place of business in Bisbee, complete loss of use of the main site and any satellite sites, loss of primary computer system/records, or networks, how CHS will communicate with AHCCCS during a business disruption with the name and phone number of a specific contact in the Division of Health Care Management. CHS performs periodic testing of the Plan but at least annually. Results of the tests are documented and reviewed with staff as needed. This is especially important for the Provider Services staff members as liaisons to the provider network.

All CHS staff attends Cultural Competency Training at least annually. This training is geared toward ensuring that services are provided effectively to members of all cultures and to promote cultural sensitivity. Training is customized to fit the needs of staff based on the nature of the contacts they have with providers and/or members. The education program will also be designed to make providers and subcontractors aware of the importance of providing services in a culturally competent manner. CHS also makes additional efforts to train (or assist providers and subcontractors in receiving training) in how to provide culturally competent services. This is accomplished by Provider Services staff in conjunction/collaboration with the Finance Department and Claims Educator.

All CHS staff attends Fraud and Abuse training at least annually. CHS Administration will ensure all employees, providers, and members receive adequate training/information regarding fraud and abuse. This is accomplished through a comprehensive training program including AHCCCS rules/regulations, fraud and abuse prevention, recognition and reporting. Educational efforts encourages employees, providers, and members to report fraud and abuse without fear of retaliation. During CHS orientation, all new employees are required to take the Deficit Reduction Act PowerPoint testing offered by AHCCCS through the AHCCCS web page. This is especially useful training to Provider Services representatives who in turn audit providers' policies/procedures and provide staff training during onsite monitoring visits.

All CHS staff attend an Emergency Preparedness training at least annually. CHS Administration coordinates this training in conjunction with the annual review and update of the Emergency Preparedness Plan. Training will typically be incorporated into the agenda of a quarterly staff meeting, with staff being required to initial that they have received and read a copy of the updated Plan each year. This is an important training element for all staff in the event emergent situations arise. For example, after recently experiencing a record freeze in our GSA, Case Managers contacted each of our members to ensure the safety and well-being of our members. In addition, Provider Services staff contacted an Emergency Alert Contractor who also assisted with this endeavor to ensure the safety of our membership during this very unusual severe weather event.

Staff are also trained in the geography of Cochise, Graham and Greenlee counties. They are given access to and instructions in the use of internet map search engines, such as Google Maps or MapQuest, for the purpose of recommending providers in, and transporting members to, the most geographically appropriate locations in the GSA. Here again, Provider Services staff benefit from this training through our relations with the transport network for providers. There are specifications in the contracts that require the provider to take the most direct route and also to attach trip reports with each claims submission. At times Provider Services staff is asked to mediate situations either through prior authorization or claims issues where the Provider Services representative acts as the liaison to ensure an appropriate resolution for all parties. In addition, this is most helpful for staff for on-site monitoring purposes given the vast rural geography of our service area.

Mandatory educational programs are incorporated into the Agendas of quarterly staff meetings whenever possible. Staff may also receive training outside of CHS and/or online upon approval of Supervisor.

Training for staff is tracked by sign-in sheets at each training session. Copies of the sign-in sheets are sent to the Administrative Coordinator (or designee) after each session. Employees who attend programs outside CHS and/or online send proof of attendance to the Administrative Coordinator (or designee) along with a notation about which category of mandatory training the program addressed – a copy of the cover page of the program will suffice. Documentation of training outside of CHS must be signed by the employee and the supervisor. The Administrative Coordinator maintains all training attendance records on an on-going basis for staff review and audit purposes, as necessary. If certificates are provided (at the option of the presenter) and given to Administrative Coordinator, they will be placed in the personnel file.

A log is maintained in the CHS network files by the Administrative Coordinator to track mandatory in-service attendance. Employees as well as Supervisors are responsible to ensure that training requirements are met each year.

Several online training opportunities are available and encouraged including:
http://www.aaaceus.com/courses/MM1004_overview.asp?quid=VKFPPDGIJI121200617019
www.azahcccs.gov
www.nursing.arizona.edu
www.nih.gov

MANDATORY TRAININGS (ANNUAL)

CHS employees are required by AHCCCS to attend specific in-services on an annual basis by contract year, which is October 1 – September 30, as follows:

- **Fraud & Abuse** *(set up by M/UM)*
- **Cultural Competency** *(set up by M/UM)*
- **HIPAA** [Health Insurance Portability & Accountability Act] *(set up by M/UM)*
- **Behavioral Health** *(set up by M/UM and/or CM)*
- **Emergency Preparedness** (*Scheduled during a quarterly staff meeting by Director*)
- **DRA** [Deficit Reduction Act] *(Initial training through CHS orientation and set up annually by M/UM)*

In addition to these resources, the CHS Provider Manual and specific Provider Services or Contracts policies are used to orient Provider Services staff. A full listing of policies is available on the CHS website at: http://www.co.cochise.az.us/CASS/Doc/ProviderManual/Provider%20Manual%20White%20Pages.pdf. Any policies not listed therein are available upon request.

Finally, CHS maintains a regular schedule of employee evaluations. These evaluations include specific job description and standards to ensure that staff is competent, as well as to identify any areas where staff may need assistance, set goals for improvement, or offer praise for meritorious performance. Cochise County Human Resource Dept has recently set forth a new standardized mechanism for supervisors countywide to measure employee performance on an annual basis. This guide is available upon request.

Cochise Health System Provider Relations Department is currently comprised of four staff members: the Chief Operating Officer (COO), a Program Coordinator, Contracts Specialist, and an Administrative Assistant. This department is responsible for many different aspects of the daily operations for CHS including, but not limited to: Provider Network Development and Management, Grievance and Appeals, Cost Avoidance (Liens), Health Information System data management, Credentialing, and member and provider publications such as Handbooks, Manuals and Newsletters. The COO is also the CHS' Contract Compliance Officer and serves as the primary point of contact for all Contractor operational issues.

Each Provider Services Representative is responsible for an aspect of departmental operations as outlined in the job descriptions. Some of these tasks overlap, with the intent of ensuring continuity of business operations in the event that an employee is absent for an extended period. As required by contract, CHS maintains "... sufficient personnel for the provision of all covered services, including emergency medical care on a 24 hour-a-day, 7 day a week basis." CHS staff reviews the current network status and identify network deficiencies gaps and/or limitations, provider guidelines, and continually monitor providers for compliance with AHCCCS Network Standards. This ensures appropriate availability of providers based on the volume of members, member needs, geographic location and projected growth.

The Chief Executive Officer/Director (CEO) and COO are responsible for ensuring that CHS staffing levels, including Provider Services department, are adequate to meet the needs of our membership and network providers. This is accomplished in part through a regular schedule of employee evaluations. Provider Services Staff are evaluated by job description and standards to ensure that employees are competent and to determine adequacy of job performance. If there were a failure to meet performance expectations, the COO would then determine if this failure was employee specific or the result of expanding needs of the provider community. From this point the COO would address the issue with the CEO for corrective action that may include redistribution of workloads with existing employees within the organization or a request for recruitment to ensure that CHS meets and exceeds not only the AHCCCS Provider Network performance expectations, but meets our organizations' goal of excellence in customer service.

Measurements for Provider Services Staff Efficacy: CHS would deem staff levels inadequate if particular aspects of operations were not being met, i.e., a reported lack of responsiveness by Provider Services Staff, provider monitoring incomplete or past due, credentialing outdated or expired contracts. Measurements of efficacy could source from both external and internal mechanisms currently in place throughout the organization. These feedback systems include, but are not limited to: provider monitoring, provider and member surveys (including telephonic surveys), the grievance system process to include Expressions of Dissatisfaction, Quality of Care Concerns, member appeals or claims disputes, CHS Call Tracking System for tracking/trending provider inquiries and other communications, Member and Provider Council, the Medical Utilization Management Process Improvement Committee, CHS staff participation with community organizations. An example of community involvement is the CHS CEO is an advisory board member for a federally qualified health care center in Cochise County. CHS is so rooted in this county given our eighteen years of experience that providers do not hesitate to contact us and let us know if something is unsatisfactory. In fact, most of CHS' providers communicate on a first name basis with CHS staff – some of the current staff members have also formerly held positions in this small provider community. This in turn helps CHS measure ways to improve the level of satisfaction and meet provider community needs, such as organizational restructuring or hiring additional personnel to improve services if provider needs were not met. It is noteworthy that over the past eighteen years, through these feedback mechanisms and State Audits including the Network Development Plan and other performance measures conducted by AHCCCS, our organization has continually demonstrated positive performance results for meeting provider service needs and achieving member satisfaction.

Internal mechanisms to evaluate Provider Services Staff levels include the CHS Interdepartmental Coordination Policy, the Leadership Team Meetings, Quarterly Staff meetings, Quality Circles and other subgroups within the organization. Each of these groups/teams serves a different purpose within CHS, but holistically have the same goal of continually finding ways to improve our performance in managing the provision of comprehensive quality

healthcare to our membership. CHS also works toward shaping tomorrow's managed healthcare environment and promotes the values of choice, dignity, independence, individuality, privacy, and self-determination by maintaining a provider network that is diverse and flexible. Through these forums, CHS Leadership is able to identify opportunities for improvement within any department, not just Provider Services. All of these processes and workgroups certainly serve as feedback loops to measure the efficacy of the Provider Services staffing levels.

The future needs of membership and provider network services are also projected by an Annual Review of Membership Growth. At least annually, the CHS Leadership Team reviews projected population growth, specific trends in service delivery, and the effectiveness of provider recruitment efforts during the past year. In October 2009 our membership was at 924, in March 2010 the membership decreased to 908 and by September 2010 the membership has further decreased to 884. Overall, our membership decreased over the contract year as evidenced by the comparison of 941 in 2008 to 949 in 2009 and 884 in September 2010. Throughout the many years in service as a Program Contractor, CHS has met the needs of our members and provider network. CHS ensures this by analyzing information gathered through provider monitoring, annual surveys, provider census information, case managers, member grievances, and provider complaints process. Other tools CHS uses to measure the adequacy of Provider Services staffing levels are quality of care concerns, Medical / Utilization Management (M/UM) quarterly statistics/annual reports, CHS Leadership Team Meetings, Quality Circles and the Inter-rater Reliability Work Group. All of these methods are used to measure the effectiveness and adequacy of our Provider Services staffing levels to determine future network needs and to determine the effectiveness of actions taken to address any network issues. Measurements also include the capacity for meeting the Minimum Network Standards or specific growth trends in specialty populations. If a growth trend is identified, the CEO and COO as well as other members of the Leadership team would closely monitor the efficacy of the Provider Services Staff to ensure that provider and member needs were met. .

CHS Case Scenario/Example:

CHS has chosen a case example to highlight the check and balance systems inherent within our organization that continually provides CHS with opportunities for improvement. This scenario is specific to Provider Services Staff.

An Expression of Dissatisfaction (EOD) is received by a Case Manager. The caller states that there is a new doctor available in town, but the member was unable to make an appointment as he was informed that the doctor was not contracted or credentialed with Cochise Health Systems. The Case Manager then contacts the Provider Services department to inquire about this physician/provider and to coordinate a resolution for this member. Provider Services staff timely respond to the inquiry by promptly researching and determining the appropriate course of action. Staff determined that the physician is in the midst of the formal credentialing process and is a new provider for Chiricahua Community Health Centers, Inc. (CCHCI). This Clinic is a Network Provider in Cochise County with satellite offices in multiple locations, such as Douglas, Elfrida, and a main office in Bisbee. This new doctor offers services through the Douglas Clinic and was recently temporarily credentialed within the appropriate 14 day time frame (as required by CHS and AHCCCS policy) and the Provider was a sent notification letter. In this case, the Provider Services department determined that the notice was not yet been relayed by CCHCI to their Douglas Clinic (it was a recent transaction taking effect only days prior to the request). CHS Provider Services contacted the Douglas site to clarify the physician's credentialing status and the member was subsequently able to schedule a visit with the doctor as requested. The EOD was timely processed, resolved, and is forwarded to M/UM Department for analysis and trending. M/UM reviews this EOD and finds no trends. The Provider Services staff was able to timely and appropriately respond to the EOD and meet the needs of both member and provider and resolve the situation. Had the Provider Services staff not responded in a timely and appropriate manner, the department manager (COO) would determine why this had occurred and address any staffing needs identified.

Provider networks are the foundation that supports membership needs and therefore by design must be diverse and flexible enough to meet a variety of member or provider issues on an immediate basis and in the long term. Throughout the eighteen years as a Program Contractor for the ALTCS program, Cochise Health Systems (CHS) has encountered very few situations involving the loss of either a skilled nursing or assisted living facility. However, in these rare instances, CHS was able to quickly transition members while maintaining continuity of care, member safety, and honoring member choice.

CHS maintains a comprehensive network of Providers that exceeds the minimum network requirements for both Skilled Nursing Homes and Assisted Living Facilities. CHS enters into Letter Agreements to provide services not immediately available within our formal Network (services outside the minimum network requirements) until a contract is awarded through the procurement process. Given the inherent challenges of a rural area, CHS takes actions to further strengthen the network to help manage any unforeseen circumstances, giving members' choice through a flexible network, by entering into agreements with skilled nursing home and assisted living facilities/alternative residential homes in Pima and Maricopa Counties as well.

Any deficiencies or gaps/limitations are temporarily resolved with Letter Agreements while the formal contracting process is completed. Identified network deficiencies considered material changes are reported to AHCCCS in advance of the anticipated change and any unexpected major network changes are reported to AHCCCS within one day of the change.

Long Term Care/Skilled Nursing Facilities (SNF) - Current Status of the Network:

The CHS minimum network requirement is for five SNFs in Cochise County, one in Graham County, and one SNF within a one hour drive from Greenlee County. Currently, CHS has contracts with all six nursing facilities between Cochise and Graham County. In the Benson and Willcox areas, CHS has also contracted with the two hospitals for Swing Bed services. In addition to this, CHS maintains contracts with eight SNFs in Pima County and this year has added Scottsdale Village Square and Maryland Gardens in Maricopa County, and maintains a Letter of Agreement with Desert Haven (sister facility to Santa Rosa Care Center in Tucson) for members whose needs cannot be met within the contracted network. While CHS meets all Minimum Network Requirements for skilled nursing facility services, some available providers may be at capacity and occasionally maintain waiting lists. In addition, there are no facilities in our GSA that specialize in behavioral health. Therefore, to prevent any gaps in service, CHS contracts with a multitude of facilities in the Pima County area, seven of which have Behavioral Health Management Units. Whenever necessary, Letters of Agreement with SNFs in Pima or Maricopa Counties are secured. Our network is structured to exceed the minimum network standards to ensure member placement in the event of facility closure or contract termination and to allow some cushion should facilities reach capacity to prevent any gaps in service. This strategy also serves to provide options, particularly for members with highly specialized needs, behavioral problems, or rare diagnoses. These additions ensure continuity of care should any of the contracted facilities in the GSA abruptly discontinue services.

HCBS Community (including Alternative Residential Settings) - Current Status of the Network:

Assisted Living Facilities (ALFs) - the CHS Network contains 20 ALFs: 14 in Cochise County, 2 in Pima County, and 4 in Graham County. There are no ALFs in Greenlee County. For members with Behavioral Health (BH) needs, six of the ALFs in Cochise County are contracted for BH services and two in Pima are contracted for BH services. In addition, the two Maricopa based SNFs also provide BH services for CHS as needed. CHS is contracted with Intermountain of Tucson who runs a variety of different homes and offers a variety of BH services in the Tucson area. Blake Foundation provides Behavioral Management services in Cochise, Graham and Pima Counties. Approximately one hundred and one members reside in twenty contracted ALFs scattered throughout our GSA. The Minimum Network Standards specify three ALFs in the Graham/Greenlee County Networks (combined). This is no longer considered a gap. At one point, there were only two Assisted Living Homes (ALHs) available in Graham County; however, currently CHS has four ALHs available to members.

Transition Process in the Event of a Contract Termination or Closure:

In the event that CHS experiences a Material Change to the network, such as a contract termination or closure of a SNF or ALF, CHS follows AHCCCS Policy including immediate notification to AHCCCS regarding the change. Notification would include how or if that change will affect the delivery of covered services, and how CHS would maintain the quality of member care in the delivery of covered services. CHS also provides timely notification (per AHCCCS policy) to members, family and/or representatives and providers. As an experienced Program Contractor, CHS maintains policies and protocols for the management of these events. CHS has contract termination provisions in all contract types that require a ninety day termination notice and provisions that do not relieve the Contractor of obligations that are reasonably necessary to complete the treatment of members and to cooperate with the CHS when arranging for the discharge/transfer of members. This cooperation includes cooperation past the formal termination of the agreement up to 12 months. Regardless of which entity terminates the contract or the reason for contract termination, CHS ensures that members' needs are met during the time of contract termination and transition phase to another facility. CHS also maintains contractual provisions that enable CHS to terminate an agreement with twenty-four hours' notice when the Agency deems the health or welfare of a member is endangered.

As soon as CHS is notified of a facility closure or in the event of a contract termination, AHCCCS is notified of this event. A meeting of CHS, SNF or ALF, and AHCCCS is held prior to the effective date of the closure (whenever possible) or contract termination to plan all aspects related to the change in contract status and impact on members and/or representatives.

CHS, in collaboration with the SNF, ALF and AHCCCS, develops a member/ representative communication plan. The purpose of the communication plan is to provide affected members and/or their representatives with consistent information regarding the contract termination or closure. CHS shall receive approval of the member / representative communication plan from the AHCCCS DHCM. Member communication timelines are in accordance with the requirements outlined in AHCCCS policy.

When a facility closure or termination includes deficiencies that jeopardize the health and safety of the member, immediate action is taken which includes, but is not limited to, the following actions: the removal of the resident(s) from the home/ facility, evaluation of the members safety and health by the appropriate healthcare professionals, notification to Adult Protective Services (APS) and ADHS or other entities as deemed necessary/appropriate, initiation of a quality of care concern case, and termination of the contract. CHS would determine the level of severity of the quality of care issue(s) and the resolution of the issue for the member and systemic resolutions may occur independently, i.e., removal of resident and subsequent termination of the contract following outcome of the quality of care concern evaluation and resolution process. It is important to note that that in the event overall quality of care places residents in immediate jeopardy, a member may choose to continue to reside in the facility. If this occurs, CHS will coordinate efforts with the member, facility, and appropriate authorities such as APS, ADHS, AHCCCS, etc., in the interim of the quality of care resolution process. If a member chooses to reside in a facility and the contract is subsequently terminated, the member shall be given proper notice via Notice of Action in accordance with AHCCCS policy. The CM will work with the member(s) to help educate them about their rights and responsibilities when choosing to reside in a non-contracted facility, the Notice of Action and rights to appeal and to request a State Fair Hearing.

If an immediate or emergent coverage problem is identified within the network, the problem is reported to the Chief Operating Officer (COO). The COO may negotiate a Letter of Agreement with an out of network (OON) provider whenever deemed medically necessary if services cannot be met within the network of providers, with approval from the CHS Chief Executive Officer/Director. The negotiation process includes the efforts of the CHS Management Team to verify that the services are medically necessary and secured with the most appropriate AHCCCS registered provider who will deliver quality services to the member. Attention is always given to any other payor source who may be involved so that CHS is the payor of last resort. The provider is then credentialed in accordance with AHCCCS AMPM policy. Whenever possible, formal/standard contracts are secured with the OON provider to expand the capacity of the network.

The CHS transition team is comprised of Case Management (CM), Medical/Utilization Management (M/UM) and Provider Relations/Contracts (PR/C) and uses the ALTCS Guiding Principles to develop a member-centered plan with

a priority placed on allowing members, when appropriate, return to their own home versus having to reside in an institutional or alternative residential setting. CMs are the binding agent that makes this strategy possible. They are the gatekeeper and facilitator, care coordinator and service broker. CHS' goal is to provide our members the necessary supports to allow them to maintain their dignity and independence in the most appropriate and least restrictive setting that can meet their needs. When there is a contract termination or closure, this team initiates the transition process with a visit to the facility to ensure that member needs are being met in the interim of the transition. This would include evaluation of member needs, health and safety by the appropriate healthcare professional(s). From this point, CHS CM visit to assess the member using the Uniform Assessment Tool(UAT) to determine the appropriate level of care (LOC) assignment for member placement. The CM also works with the member/representative to find the most suitable placement acceptable to the member. If a CM identifies that a member's level of care has improved, a feasibility study is conducted to determine if a member has the support system in place to return to an in-home setting. If this is determined feasible, the CM coordinates services to reintegrate the member into an in-home setting. The CM would also offer Community Transition Services to those members who qualify to assist the member in the reintegration process. This would be in accordance with the new AHCCCS policy set forth February 2011.

If the member is not able to return home, CHS CM would assess the member using the UAT to determine the appropriate LOC assignment for member placement in the least restrictive setting acceptable to the member. It is especially noteworthy that CHS contracts with as many facilities as possible (as stated herein) to aid in the event of these circumstances. This comprehensive CHS network gives members choice in placement options, rather than offering the member only one choice that may be far from family/friends and home (place they grew up and are familiar with). The network is also comprised of facilities outside the GSA in Tucson or Phoenix for members with special healthcare needs that cannot be met in network. Overall CHS is able to offer options to members when there is a contract termination or facility closure. The CM team coordinates the completion of the transition, including transportation, once the PCP completes the admission orders and schedules the initial assessment. The CM ensures that appropriate documentation regarding the member is sent to the receiving facility, including, but not limited to: Face Sheet/HP, Current Physician Orders, Med Sheet, Treatment Sheet, Care Plan, Negative TB Test or CXR. If possible, the member's medications accompany the member to the new SNF/ALF. Considerations are always made for members with Special Health Care needs when transitioning to a new facility.

Reimbursement rates/methodologies vary between SNF and ALF, including add-on rates for higher LOC or for members with special care needs. This information is specified in the provider's contract or negotiated through Letters of Agreement. For established providers, there is no change in established contract rates or methodologies with the transition of members. At times facilities disagree with a LOC determination and CHS cooperates in a second review. When a facility disagrees with an LOC decision, the CM attempts to remedy the situation with this secondary review. If this does not resolve the issue, the provider may speak to the Chief Operating Officer and/or the Chief Executive Officer to mediate the situation and is advised of the claims dispute process.

Reimbursement shall be set at the applicable AHCCCS FFS rates (urban/rural) as periodically amended for SNFs or as set forth in contracts for ALFs. As previously stated, any add-on for increased rates for special care needs will be considered when placing members. Here again reimbursement methodologies follow AHCCCS policies. In addition, CHS shall account for a member's Share of Cost (as applicable) for SNF or Room and Board (R & B) for ALF. The reimbursement for an ALF is set forth in the provider contract and includes the personal care services a member receives during placement. This rate is prorated per day based on the date of placement or transition (for refunds). For ALFs, R & B is not a covered benefit under the ALTCS program and Medicaid funds cannot be expended for R & B when a member resides in an alternative residential setting. These setting include Assisted Living Homes, Behavioral Health Level 2 facilities, and/or an apartment-like setting that may provide meals. CMs work with members to explain what homes/centers are available and assist them in the transition process. This may include assistance in any refunds for R & B particularly to help with payments to the next home as applicable.

Following transition to a new facility, CHS CM will assess the member's situation and acclimation to the new setting. If any issues are identified, the CM will determine the best course of action depending on the nature of the situation. Emergent situations identified by the CM or reported by the facility will be processed through our Medical /Utilization Management Department who shall determine the appropriate course of action in collaboration with the case manager, member and/or representatives and member's primary care provider, and CHS Medical Director if needed.

COCHISE HEALTH SYSTEMS (CHS) PROVIDER NETWORK SUBMISSIONS # E44

The CHS Provider Network is the foundation that supports members' needs and choice. It is designed to reflect those needs and all AHCCCS service requirements. All provider sub-contracts comply with Federal and State laws and regulations including, but not limited to, AHCCCS Minimum Subcontract Provisions, the criteria set forth in Section 33 Subcontracts of the AHCCCS contract, and/or AHCCCS Policy Manuals. Before entering into any type of subcontract, CHS evaluates the subcontractor's ability to perform services under the terms and conditions of the agreement and applicable state and federal guidelines including AHCCCS policy. At the time of contracting, providers are also credentialed in accordance with AHCCCS policy.

Overview: As an experienced Program Contractor, CHS has employed various methods to operate efficiently. These mechanisms are also used as a means of reinforcing the integrity of the network foundation throughout the term of a provider sub-contract. These mechanisms are processes, i.e., the grievance system to include Expressions of Dissatisfaction (EOD) and Quality of Care (QOC) concerns, member and provider surveys, pre and post payment claims review processes, and provider onsite monitoring to list a few examples. Other internal sources include Interdepartmental Policies and Teams such as the Leadership Team, CHS Quality Circles, and periodic staff meetings or other workgroups in all departments within CHS.

Monitoring. One of the most important and effective means of identifying provider performance issues are the Operational Onsite Reviews. CHS conducts operational on-site monitoring to ensure that the provider complies with all Federal, State and local legislation, rules and regulations relating to the provision of services under the terms of the agreement. The Contractor is also evaluated to ensure that the provision of services is in compliance with AHCCCS Rules & Regulations (Acute Care), ALTCS Rules & Regulations, Arizona Department of Health Services Rules & Regulations, and the Arizona Revised Statutes.

Monitoring is a shared responsibility between Provider Relations/Contracts (PR/C) and the Medical Utilization and Management (M/UM) Departments. As a shared responsibility, the PR/C department focuses on the operational review of a provider, including an evaluation of employee records, while the M/UM department focuses on the member care aspect of services. Onsite facility assessments are typically conducted for all contracted providers on an annual basis, or at least every three years to ensure compliance with AHCCCS Policy, CHS contractual requirements and to evaluate the quality of services delivered to members. Monitoring includes assessments to determine the adequacy, accessibility and availability of the provider network. The onsite reviews are conducted using monitoring tools developed in accordance with contractual requirements, state and federal regulations, and AHCCCS policy specific to the provider service type being reviewed. CHS reviews providers' policies/procedures, such as fraud/abuse and cultural competency. If a facility is being reviewed, the onsite assessment will include, but is not limited to, items such as menus, activities for members, licensure and credentials, and randomly selected personnel records. PR/C staff also verifies CHS provider manual maintenance. Surveyors assess contractors for their efforts in the promotion of cultural awareness and the providers' ability to accommodate members with different ethnic backgrounds, such as bilingual staff or intake forms in different languages. The M/UM department review process includes member chart evaluation with review of diagnosis, treatment and follow-up care to determine whether certain Covered Services provided, or to be provided, to members are in accordance with CHS and AHCCCS requirements. M/UM RN surveyors also analyze information such as EODs and/or QOC Concerns, other pertinent medical records, and/or trended information gathered within the organization that would assist in the determination of the provider's performance under the terms and conditions of the contract.

Corrective Action Plans: If the surveyor's findings are unsatisfactory and it is determined the provider is in any manner in default in the performance of any obligations of the Contract, CHS requests a Corrective Action Plan (CAP) from the Agency. A CAP is a written work plan that includes goals and objectives, steps to be taken and methodologies to be used to accomplish CAP goals and objectives, and identifies staff responsible to carry out the CAP within established timelines.

In accordance with AHCCCS contract requirements, the PR/C Section will in writing promptly inform AHCCCS DHCM, if a subcontractor is in significant non-compliance that would affect their ability to perform the duties and responsibilities of the subcontract. The CAP shall include the actions to be taken by the provider, such as staff education, training, or technical assistance. Follow-up monitoring is also completed by CHS for evaluation of improvement, changes in processes, structures, forms, and informal counseling. The CAP may also include plans and activities to correct deficiencies and/or increase the quality of care and services provided to members. Other actions

may include initiating Performance Improvement Projects to address trends identified through monitoring activities, review of complaints, review of quality of care cases, provider credentialing and profiling, and utilization management reviews. Depending on the severity of the deficiency and/or the subsequent results of the CAP, CHS may suspend modify, or recommend termination of the provider's contract immediately upon written notice to Contractor. This action may be taken in the event of a non-performance of stated objectives or other material breach of contractual obligations, or upon the occurrence of any event that would jeopardize the ability of the Provider to perform any of its contractual obligations. Such determination would not be made until the dispute process had been exhausted as specified in the Disputes Clause of the Provider's Subcontract. If an adverse action were taken with a provider due to a quality of care concern, CHS would report the adverse action to the AHCCCS Clinical Quality Management Unit, and/or refer to regulatory agencies. Documentation of assessment of the effectiveness of actions taken is maintained by the M/UM department. CAP and subsequent results are shared with the CHS Leadership Team, the M/UM Process Improvement Committee, and others as deemed necessary, including members and providers if the provider network is impacted.

Grievance System: CHS also monitors provider performance and/or issues through the grievance system process. This includes, but is not limited to EODs, QOC concerns, Member Appeals and Claim Disputes. CHS staff maintains a tracking and trending log for each type of grievance that is received, reviewed and resolved and performs periodic trending analysis to identify problems and issues in provider performance. Through this process, CHS staff requests a CAP from the provider as described above, including follow-up monitoring by CHS. Findings from the analysis are used to improve quality of care and services for members, provider network and CHS as a whole. A trend is defined as the receipt of problems/complaints regarding the same member that number three (3) or more in a one (1) month period, or five (5) or more within a three (3) month period. If a trend is identified, the quality of care process is begun to investigate the member situation. For Provider findings that are unsatisfactory and determined to be in default of performance/contractual obligations, CHS requests a CAP from the provider. All trends are discussed with the Leadership Team and CHS Medical Director for review and recommendations. If there are provider trends substantiated through this process that continue to be of concern, discussion is held with the CEO and COO to determine the appropriate course of action and resolution. All pertinent information is documented and maintained by the appropriate department (PR/C or M/UM). All trends are kept for reference in the involved provider's profile for review upon re-credentialing and/or during contract renewal. All trends are also discussed at Medical/Utilization Management/Performance Improvement Committee (M/UM PIC) meetings quarterly.

Provider and Member Surveys: are mailed annually to gather information regarding the network and about the organization. They also serve to help CHS identify any provider performance issues. The surveys cover a range of topics including, but not limited to, satisfaction with services, timeliness of services, and satisfaction with providers/network. In addition, CHS conducts random annual physician accessibility surveys during regular office hours based on standards developed and approved by the Leadership Team and M/UM PIC. This helps CHS address any provider performance issues in the network by ensuring that PCP appointments (including out-of-network referrals), medical services, and advice are available to CHS members within the standards established by AHCCCS. This survey feedback helps CHS identify our strengths as well as provider performance issues that may need improvement. The results are analyzed by the Leadership Team and M/UM PIC for trends that may lead to provider or internal staff education and overall serve as a tool to improve our operations and network.

Claims Review, Utilization Reports and Statistical Analysis: CHS staff conduct pre and post payment claims review that serve as process improvement tools in many areas. For example, within this context CHS utilizes the claims review process to identify any potential performance issues with provider claims submission/billing practices. Should any trends be identified the Chief Financial Officer (CFO)/Claims Educator and COO offer assistance and training to the provider to help improve their performance, or may request a CAP if deemed necessary depending on the nature of the trend. As an example, through this process CHS identified a negative trend in HCBS Provider billing practices, hosted meetings with these providers to identify the specific issues identified, and CAPs were also requested from the providers. Since these interventions, CHS has observed an overall improvement in the accuracy of HCBS claim submissions. The results of this study were presented to other Program Contractors and AHCCCS and are available upon request. The M/UM department also conducts pre and post payment claims reviews with monthly reports/statistical analysis and results are presented to the Leadership Team and to the M/UMPIC for review and action as deemed appropriate. If any trends are noted regarding provider performance issues, CHS then approaches the provider requesting a CAP for process improvement.

Member Verification of Services-CHS also conducts quarterly verification of services through random/periodic audits to validate that members receive services for which CHS reimburses providers. This process also serves as a mechanism to identify any performance issues with providers, such as billing issues or organizational issues. CHS can also identify that providers billed for services not rendered to members through this process.

M/UM Process Improvement Committee (M/UM PIC): is a CHS subcommittee where results of provider monitoring, surveys, and grievances are reported. The group meets quarterly as a means of verifying stability within the organization and the network, and soliciting feedback from committee members. Provider performance trends identified from any of the means discussed above are addressed through provider meetings and, if necessary, a CAP is requested.

Provider Call Tracking: All CHS staff is required to track and trend all provider inquires/complaints/requests with the Provider Call Tracking software application. Results of the call tracking system are analyzed by the Leadership Team and process improvement plans are set forth whenever deemed necessary based on the results of the database query results. Within this software application, CHS has the ability to extract data though a series of SQL queries or scripts (reports from database) that enable us to identify any trends in provider issues.

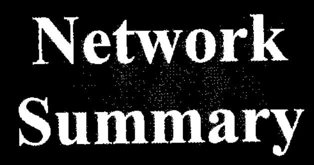
Provider Credentialing: the CHS credentialing process, which adheres to the guidelines set forth by AHCCCS, provides another means to identify and address any provider deficiencies. Each provider is initially credentialed and is then re-credentialed every three years thereafter. Part of this process entails the **Provider Profiling Process** completed by the M/UM department. Each provider file that is re-credentialed is reviewed based on CHS historical data including EOD, QOC concerns, provider utilization, member complaints and survey results that are then reviewed by our physician panel to determine if the provider performance is satisfactory and meets CHS requirements and performance expectations of network providers.

Interdepartmental Collaboration: CHS has in place an interdepartmental process that serves to promote coordination and communication across disciplines and departments within CHS. This is accomplished through regular meetings of the Leadership Team, Quality Circles, staff meetings, Inter-rater Reliability Workgroup meetings, and other workgroups as needed. The purpose of this collaborative process is to improve ongoing communications among CHS departments, with particular emphasis on ensuring coordinated approaches in medical and quality management. This internal collaboration serves as a feedback mechanism that allows CHS to monitor the performance of our providers and quickly remedy any situations before they become chronic situations. Any issues identified are routed through the Leadership Team for the appropriate course of action that may include a CAP and working with the provider to remedy the situation.

Sanctions: Over the years, our rural counties have grown and more medical services are available. It is essential to build strong ties within our community and solidify the foundation of our organization through a strong Network. Whenever possible, CHS works with providers to manage performance issues through our CAP process (that has be mentioned throughout this document), with education, training and monitoring to make sure the provider is compliant, reliable and provides quality services. However, despite these efforts there are occasions when these methods are not successful. CHS developed a Provider Sanction Policy to sanction providers for repeated sub-standard performance or other breach of contract or procedural provisions. If the provider is in any manner in default in the performance of any obligation under their Agreement, CHS may, at its option and in addition to other available remedies, adjust the amount or withhold payment to the Provider until there is satisfactory resolution of the default. This sanction process is a contractual clause and the policy is listed in the provider manual along with Provider appeal rights and process. This sanction policy was approved by AHCCCS and is in accordance with Federal and State laws.

The sanction process is a mechanism used to address provider performance issues. Prior to sanctioning a provider, CHS seeks a CAP from the provider, offers support, and monitors compliance. Should the provider adhere to the CAP with no further occurrences, the CAP is accepted and the provider agreement is not suspended or terminated. However, CHS does maintain the right to terminate a contract as set forth in each agreement and states that the CEO may suspend, modify, or recommend termination of the Contract. This may be an immediate remedy upon written notice to Provider in the event of a non-performance of stated objectives or other material breach of contractual obligations, or upon the occurrence of any event that would jeopardize the ability of the Contractor to perform any of its contractual obligations. Such determination is not made until the dispute process has been exhausted as specified in the Disputes Clause of the Provider's Subcontract.

Over the past eighteen years, CHS has created and employed many mechanisms to promote communication, collaboration within the organization, network management, and identify process improvements to address provider performance issues. In our experience, working with providers through CAPs, support, education, and training has proved far more successful than the termination of a valued provider.


Network
Summary

COCHISE HEALTH SYSTEMS PROVIDER NETWORK SUBMISSIONS # E45

Cochise Health Systems has developed and maintains a provider network, supported by written agreements, which is sufficient to provide all covered services to ALTCS members in GSA 46 and exceeds the minimum Network Standards as established by AHCCCS. A full Network Summary and Network Attestation Statement will be uploaded to the CHS designated folder on the AHCCCS EFT/SFTP server no later than 3:00 PM on April 1, 2011.